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ABSTRACT

This document consists of an instructor's manual and student manual for a nurse assistant curriculum. The instructor's manual provides answers to activity sheets and unit evaluations along with individual unit overviews. Suggested teaching strategies and audiovisual supplements are included for each lesson. The student manual contains eight units: (1) introduction to nursing, (2) employment, (3) interpersonal relationships and communication skills; (4) safety; (5) personal care; (6) restorative nursing; (7) nutrition; and (8) special procedures. Units are further divided into lessons that consist of lesson objectives, key terms, content information, illustrations, and activity sheets as appropriate for the content. Each unit contains a written evaluation, skill sheets, and a unit checklist. A competency record sheet and a certificate of achievement are also included in the student manual. The curriculum is designed to be used by students who are in secondary health occupations programs. (KC)

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Nurse Assistant

in Acute, Home Health and Long-Term Care Settings

Instructor Manual

Instructional Materials Laboratory • University of Missouri-Columbia
Missouri Department of Elementary and Secondary Education

Nurse Assistant in Acute, Home Health and Long-Term Care Settings

Instructor Manual

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Notice: The information presented in this publication reflects current medical standards of care to the best of our knowledge. Of course, readers are advised to be aware of local protocols, the needs and circumstances of individual cases, and their responsibility to stay abreast of emerging knowledge and clinical procedures. The authors, editors, and publishers disclaim any responsibility for improper treatment resulting from the clinical procedures outlined in this publication, for misinterpretation of the information presented, and for any undetected inaccuracies within the text.

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Instructional Strategies

This *Nurse Assistant in Acute, Home Health and Long-Term Care Settings* Instructor's Manual is designed to be used with the *Nurse Assistant in Acute, Home Health and Long-Term Care Settings* Student Manual. It provides answers to the activity sheets and unit evaluations along with individual Unit Overviews. Suggested Teaching Strategies and Audiovisual Supplements are included for each lesson. The content was developed with input from secondary health occupations education instructors; nurses; and personnel from the Missouri Division of Aging, Missouri Department of Elementary and Secondary Education, and the Instructional Materials Laboratory at the University of Missouri-Columbia.

The format of the instructor and student materials provides health occupations education instructors flexibility in their implementation of the curriculum.

Following completion of the *Health Care Assistant Core* competencies, a student interested in pursuing a career in nursing can achieve specific competencies through this curriculum. Students successfully completing this course might become employed in acute or home health care. If the student is interested in obtaining certification as a Nurse Assistant in a long-term care facility, he or she must challenge the final exam for that certification. This course also serves as a solid knowledge and skill base for continuing education in nursing.

The *Nurse Assistant in Acute, Home Health and Long-Term Care Settings* curriculum is primarily designed to be used by students who are in secondary health occupations programs. Instructors should oversee the knowledge component of instruction (including the Written Unit Evaluations) and identify a clinical site and a clinical supervisor for each student. The clinical supervisor should be responsible for supervising the student while at the clinical site, providing skill training, and evaluating mastery of skills. In many situations, the health occupations instructor is also the clinical supervisor.

Since mastery of the information and skills will be evaluated using the Written Unit Evaluations (pink) and the Skill Sheets (pink), it is recommended that these pages be removed before the manual is given to the student. These pages are located together at the end of the student manual.

A Nurse Assistant in Acute, Home Health, and Long-Term Care Settings Competency Record Sheet and a Certificate of Achievement have also been included at the end of the student manual. These could be removed and filed with the evaluation instruments.

The student manual is divided into eight units: Introduction to Nursing, Employment, Interpersonal Relationships and Communication Skills, Safety, Personal Care, Restorative Nursing, Nutrition, and Special Procedures. Units are further divided into lessons, which contain lesson objectives, key terms, content information, illustrations, and activity sheets as appropriate for the content. Activity Sheets are designed to assist the learner in mastering the information in each lesson. They also contain clinical/laboratory activities. Instructors or supervisors should review or discuss these activities with students. The Activity Sheets may or may not be graded depending on the instructor's preference.

Each unit has a written evaluation, which should be administered after all lessons in the unit are studied. A score of 80 percent indicates that the student has satisfactorily completed the unit and may proceed to the next unit. Skill sheets provide a record of mastery of the steps in the procedure for each skill. The student should practice the skills outlined in the lessons before requesting evaluation of the skills. When evaluating mastery of skills, the clinical supervisor can determine that mastery is obtained when he or she feels confident in the student's ability to perform the skill without direct supervision.

A Unit Checklist, located at the end of each unit, provides a method for keeping track of Activity Sheets and Written Unit Evaluations to be completed in the unit.

In addition to being utilized in the secondary health occupations program to prepare nurse assistants, the *Nurse Assistant in Acute, Home Health and Long-Term Care Settings* curriculum, in conjunction with the *Health Care Assistant Core* curriculum, could be used in other ways as well:

> *Acute care facilities may use may use all or part of the material in training students, volunteers or new staff members.
>
> *Home health agencies or adult day care programs may use all or part of the material in training students, volunteers or new staff members.

Unit I

Introduction to Nursing

Overview of the Unit

This unit introduces the student to the world of health care. The information presented refers to the role of the nurse assistant in three areas: acute care, long-term care, and home health care. This unit contains two lessons. The first lesson introduces the student to the health care industry and its trends, regulations, and payment systems. The second lesson discusses problem-solving and how to prioritize and organize.

Lesson 1: The Health Care Industry

Objectives:

1. Identify types of health care settings.
2. Identify the health care team members and each of their roles.
3. Identify the basic tasks of a nurse assistant
4. Define the role of a nurse assistant in acute, long-term and home health care.
5. Differentiate between the types of health care insurance.
6. Identify the impact of regulatory agencies on the health care industry.
7. Identify current trends in the health care industry.
8. Identify community resources that a client can utilize with or without assistance.

Teaching Strategies:

1. Use examples of health care facilities and home health agencies in your community to illustrate different types of health care settings. Obtain brochures or literature samples from facilities or agencies to show the class.

2. Arrange for the class to tour a hospital, a long-term care facility, and a home health agency. The class may need to be divided and assigned a facility or agency to prevent overburdening the setting. Another means of separating the students is to have them draw names of facilities or agencies to visit. As an alternative, have a representative from each type of health care setting come to the class to discuss the services offered and the types of personnel who work for the facility or agency.

3. Identify all the departments within the local hospital. In a small community, students may know the names of the administrators, department supervisors, and other health care team members. Ask students if they know anyone who works at a health care facility or for a home health agency.

4. Identify services that are not available at the local hospital and describe where and how a client can have access to them.

5. Write the title of health care members on separate slips of paper. Have each student draw a slip of paper. The students must describe the health care position and write

their names on an organizational chart. The organizational chart should be drawn ahead of time. It should have blank squares for the student's name with the title of their selected position identified under each square.

6. Obtain job descriptions for nurse assistants in acute care, long-term care, and home health care to share with the students.

7. Ask a local health care insurance agent to speak to the class about the different types of health care insurance plans. Some insurance companies may also provide videocassettes that can be used to explain different types of insurance.

8. Share with the students a copy of the *Joint Commission on Accreditation of Healthcare Organizations* (JCAHO) standards for accrediting health care organizations.

9. Have students discuss current trends in the health care industry that the health care member discussed with them during the interview listed in the clinical/laboratory activities.

10. Have students identify a social worker to interview. The person may work at a local facility, at a local social services department, at a community agency, city hall, etc. The purpose of the interview is to discover resources available in the community that could assist clients. One way to accomplish the interview would be by having the entire class create a list of questions and then appointing one student to ask the questions.

Audiovisual Supplements:

Audiovisuals available from the *Missouri Vocational Resource Center*:

1. *Careers in Caring*. Videocassette. State Fair Community College Media Center, 1991. 12 min.
2. *Direct Health Care Careers*. Videocassette. Quality Training Specialists, Inc., 1991. 10 min.
3. *Institutional Health Care Careers*. Videocassette. Quality Training Specialists, Inc., 1991. 10 min.

Activity Sheet Answers:

1. Answers should include five of the following:
   - Hospital
   - Long-term care facility
   - Home health care
   - Physician's office
   - Outpatient clinic
   - Community mental health center
   - Hospice
   - Nutrition/senior center

2. a. Intermediate-care facility
   b. Skilled nursing facility

3. The client

4. Answers should include five of the following:

   a. Physician - Makes the diagnosis and gives the orders for medication and treatment

   b. Administrator - Responsible for all aspects of the operation of the health care facility in which care is being given

   c. Registered nurse - Plans, assigns, and evaluates nursing care

   d. Licensed practical nurse - Able to perform most treatments, including giving medications; may either give complete physical, psychological, and social care to a client or may assist others with that care, depending on the setting in which the health care is delivered

   e. Certified medication technician - Prepares and administers selected medications, transcribes physicians' orders, observes and reports effects of medications, and assists with resident care

   f. Nurse assistant - Provides for and assists with activities of daily living

   g. Unit secretary - Responsible for the paperwork functions of the nursing unit

   h. Dietician - Approves menus, evaluates the dietary intake of clients, and counsels clients with nutritional problems

   i. Restorative aide - Provides ambulation, transfers, and other mobility assistance to residents

   j. Social worker - Reviews the rights and responsibilities of the client, provides counseling for social and emotional needs of the client and family, and provides discharge planning and follow-up

   k. Activities director - Specializes in activity planning and coordination; coordinates and supervises the volunteers and schedules community-sponsored activities in the facility

   l. Physical therapist - Plans and provides therapy that promotes rehabilitation and instructs staff in restorative nursing procedures

   m. Occupational therapist - Restores, maintains, or improves daily living skills, such as eating, grooming, hygiene, toileting, and dressing

   n. Speech therapist - Identifies, assesses, and rehabilitates persons with speech or language disorders, such as the inability to articulate words

   o. Respiratory therapist - Evaluates respiratory status, administers special breathing treatments, and maintains and monitors special respiratory equipment

p. Dentist or dental hygienist - Examines, cleans, and evaluates the teeth

q. Podiatrist - Gives foot care and keeps toenails trimmed

5. Although the basic role will be the same in any setting, the nurse assistant's responsibilities will vary from one facility to another.

6. a. Report client information and observations to the supervisor, as directed.
b. Assist clients with personal care.
c. Make beds.
d. Keep the clients' environment clean, orderly, and safe.
e. Assist with phases of rehabilitation, such as ambulation, turning, and positioning.
f. Provide care to the dying client.
g. Measure vital signs.
h. Assist with nutrition.
i. Perform simple procedures, such as dressing changes, measuring intake and output.
j. Care for equipment.
k. Give basic emergency care.

7. a. Acute care - In addition to regular nursing responsibilities, the nurse assistant may be asked to fulfill multiple roles, including unit secretary, housekeeper, dietary staff, and patient transport or some hospitals train the nurse assistant to do advanced procedures such as catheterization and sterile dressing changes.

b. Long-term care - Along with regular nursing tasks, the role of the nurse assistant in long-term care includes responsibilities in charting, understanding the elderly, elimination, restorative nursing and special procedures.

c. Home health care - In addition to providing basic nursing care, specifically those tasks related to activities of daily living, the home health aide may be required to perform light housekeeping and to prepare simple meals. They must be able to work without constant supervision and establish relationships with other caregivers.

8. Answers should include two of the following:
- Expanding technology
- Increased health care costs
- Short inpatient stays
- Increase in home health care industry
- Profit-driven rather than patient-driven health care agencies
- Corporate systems instead of small, stand-alone agencies
- Managed care
- Better educated public that knows its health care options
- Consumer mentality in regard to care
- Greater numbers of the elderly
- Move to health promotion

9. a. Private health insurance
b. Employer provided health insurance

c. Special insurance (worker's compensation and auto insurance)
d. HMO
e. Medicare
f. Medicaid

10. They make sure that health care agencies conform to standards imposed by federal or state goverments and assure the public and agency employees that they operate within minimum guidelines.

11. Answers should include three of the following:
    - Social services department in a health care facility
    - Social services department of the local government
    - Local offices on aging
    - Churches and synagogues
    - Support groups for caregivers in the home
    - Internet

Lesson 2: Being an Efficient, Effective Practitioner

Objectives:

1. List steps in the problem-solving process.
2. Organize workload and prioritize tasks.

Teaching Strategies:

1. Provide a simple problem (for example, being late to class) and have the students use the problem-solving process to solve it. The instructor should write down the answers on the board or on an overhead transparency.

2. After using the six steps for problem-solving to work through a simple problem, give the class a nursing-related problem. Make sure it is a problem they have already had in the *Health Care Assistant Core* curriculum; for example, an elevated temperature. Have the students work through the steps of the problem-solving process as a group with the instructor writing down the answers on the board or on an overhead transparency.

3. Develop several scenarios that describe various nursing tasks. Have students prioritize the tasks, putting them in the order in which they should be completed. This can be done as a class, in small groups, or as individual student projects. If students are working in groups, circulate among the groups to assist with their discussion. Ask the groups to submit their final listing of how they would prioritize the tasks.

4. Allow time for the students to identify methods used to organize and prioritize. Use the blackboard to record the students' answers. The instructor may want to have general categories identified before class starts, such as organizing responsibilities at home, at school, and at work.

Audiovisual Supplements (available from MVRC):

1. *Everyone's a Problem Solver.* Videocassette. United Learning, 1991. 20 min.
2. *How to Problem Solve Critical Thinking Skills.* Videocassette. The School Company, 1992. 20 min.

Activity Sheet Answers:

1.
    a. Identify the problem.
    b. Determine the cause of the problem.
    c. List all possible solutions to the problem.
    d. Identify advantages and disadvantages of each solution.
    e. Choose the best solution and try it.
    f. Evaluate the results of the solution.

2. Answers will vary since each student will have chosen a different problem on which to focus. Correct answers involve each of the six steps of the problem-solving process.

3. Answers will vary since each student has different methods he or she uses to organize and prioritize.

4. Answers may vary from student to student. Below is one way to answer the question.
    a. Put Mrs. Alvarez on the bedpan.
    b. Clean Mr. Spitz of his incontinence.
    c. Get Mr. Jones out of bed.
    d. Help Mr. Smiley call his daughter.
    e. Find Mrs. Givens' sweater.

Answers to Written Unit Evaluation:

1. d
2. c
3. a
4. c
5. b
6. d
7. c
8. d
9. b
10. a
11. e
12. b
13. i
14. g
15. d
16. c
17. h
18. d
19. c
20. h
21. a
22. g
23. f
24. b

25. Answers should include five of the following:

    a. Report client information and observations to the supervisor, as directed.
    b. Assist clients with personal care.
    c. Make beds.
    d. Keep the clients' environment clean, orderly, and safe.
    e. Assist with phases of rehabilitation, such as ambulation, turning, and positioning.
    f. Provide care to the dying client.
    g. Measure vital signs.
    h. Assist with nutrition.
    i. Perform simple procedures, such as dressing changes, measuring intake and output.
    j. Care for equipment.
    k. Give basic emergency care.

26. Step 1: Identify the problem.
    Step 2: Determine the cause of the problem.
    Step 3: List all possible solutions to the problem.
    Step 4: Identify the advantages/disadvantages of each solution.
    Step 5: Choose the best solution and try it.
    Step 6: Evaluate the results.

Unit II

Employment

Overview of the Unit

This unit prepares the student to search for a job by: describing the employment process, discussing resumes and letters of application, and identifying successful strategies in interviewing. The first lesson discusses employee's rights, declining requests beyond the scope of training, lines of authority, and the types of nursing systems. The second lesson in the unit discusses stress and the management techniques that a nurse assistant could use to reduce stress on the job.

Lesson 1: Becoming Employed in Health Care

Objectives:

1. Describe the job search process.
2. Discuss employee rights.
3. Identify requests that are beyond the nurse assistant's training.
4. Compare the lines of authority in acute, long-term, and home health care settings.

Teaching Strategies:

1. Obtain notices for job openings for nurse assistants from local health care facilities. Discuss the job requirements with the students.

2. Develop a sample letter of interest.

3. Obtain job advertisements from local and regional newspapers. An alternate suggestion is to have the students use the Internet to see if they can find any available jobs. Have the students develop a letter of application for one of the job advertisements.

4. Develop a sample resume.

5. Have the students discuss various application forms for employment. They should identify information that is common to all applications and information that is specific to certain types of health care facilities.

6. If a video camera is available at the school, videotape students role-playing an interview. One student would play the role of the interviewer while another student would play the role of the interviewee. Play the tape back and have the class critique it using the guidelines given in the lesson. Discuss appropriate and inappropriate questions that an interviewer might ask and appropriate and inappropriate responses that might be made by the interviewee.

7. Check with local health care facilities for information on employee rights. If a handout is available, share it with the students.

8. Have students role-play declining a request to give care that is beyond their scope of practice.

9. Discuss students' responses to being asked to complete a task that they have never done before.

10. Obtain organizational charts from local health care facilities. Make these into an overhead to use as a demonstration of lines of authority. Identify whether the organization is a centralized or decentralized system.

11. Identify the types of nursing systems each of the local health care facilities utilize.

Audiovisual Supplements (available from MVRC):

1. *The Seven Phases of a Job Interview.* Videocassette. JIST Works, Inc., 1988. 38 min.
2. *The Successful Job Interview.* Videocassette. AL Custom Video Productions, 1988. 20 min.
3. *Take This Job and Love It: The Keys To Surviving Your New Job.* Videocassette. Cambridge Research Group, 1993. 32 min.
4. *Effective Resumes and Job Applications.* Videocassette. The Learning Seed, 1992. 32 min.
5. *A Two Way Street: Interview Skills in Action.* Videocassette. The School Company, 1991. 20 min.
6. *Job Connection Applying for Work.* Videocassette. Center for Education and Work, 1990. 15 min.
7. *Job Interview Tipping the Odds for People Entering the Job Market.* Videocassette. Center for Education and Work, 1990. 8 min.
8. *Creating a Resume.* Videocassette. Center for Education and Work, 1990. 13 min.

Activity Sheet Answers:

1. a. Determine career goals
   b. Developing a resume - a summary of education, work experience, and skills and abilities that you have to offer an employer
   c. Asking at least three persons to serve as personal references
   d. Identify resources for finding a job
   e. Filling out the application
   f. Completing the interview - answering an interviewer's questions about you and your ability to do the job

2. Answers will vary and may include some of the following:
   - Personal contacts
   - Letters of interest
   - Telephone contacts
   - Advertisements
   - Friends/colleagues
   - Job fairs/open houses

3. a. Personal identification
   b. Work experience
   c. Education
   d. Honors and awards
   e. Membership in professional organizations

4. Answers should include three of the following:
   - Instructors
   - Former supervisors
   - Ministers
   - Physicians
   - Health care workers

5. Answers should include five of the following:
   - Plan what to wear to present a neat, clean, professional appearance
   - Dress conservatively with minimal jewelry and make-up
   - Arrive on time
   - Stand until asked to be seated
   - Watch body language
   - Know what is on your resume
   - Share information in a clear and concise manner
   - Make eye contact
   - Sit quietly and avoid using distracting mannerisms

6. a. Driver's license
   b. Social Security card
   c. High school transcript
   d. Competency sheets from nurse assistant course
   e. Certificate of completion of training program

7. Answers should include five of the following:
   - Review job descriptions
   - Understand what employers expect on the job
   - Ask for clear, written policies regarding benefits provided and performance standards
   - Discuss working conditions with supervisors or regulatory agencies
   - Communicate with union stewards if a union is present in the facility
   - Investigate whether the work environment is free of sexual harassment and discrimination
   - Determine whether the work environment is as free of as many hazards as possible with the right to request an inspection if uncorrected hazards exist
   - Locate signs posted regarding areas exposed to dangerous chemicals or radiation
   - Discuss the record of the employee's own exposure to toxic substances and the right to a medical examination if health is affected by exposure
   - Discuss the behavior of a client
   - Discuss the right to refuse an assignment or request necessary training if additional skills are needed

8. When the request is for a task that requires special training or skills

9. a. Identifies the health care workers for whom the supervisor is responsible
   b. Identifies the person to whom the worker reports to

10. a. Centralized - the lines of authority are direct from top to bottom; decision making begins at the top and is directed downward

    b. Decentralized - responsibility for power and authority has been delegated to lower levels in the organization

11. a. Functional nursing - care is divided by tasks among the members of the team

    b. Team nursing - the registered nurse takes responsibility for organizing and coordinating health care, and all members share responsibility for care of the clients

    c. Primary nursing - uses a staff consisting of only registered nurses; one nurse is responsible for the care of a client from admission to discharge and is assisted by associate nurses who fill in when the primary nurse is not on duty

    d. Case management - a registered nurse coordinates the care provided by all members of the health care team

Lesson 2: Taking Care of Yourself

Objectives:

1. Define stress.
2. Compare external, internal, and interpersonal stressors.
3. Identify the phases of stress.
4. Identify the signs of stress on the body.
5. Compare appropriate and inappropriate stress-management techniques.
6. Implement techniques to manage stress.

Teaching Strategies:

1. Have the students identify the signs of stress that they may exhibit in each of the categories. Generate a "class profile of stress" by identifying symptoms of stress common to most of the students.

2. Allow time for the students to work in small groups to discuss the stressors in their lives. After working in groups, have the students in the class discuss stressors in general and the ways the students choose to deal with them.

3. During the clinical portion of the program, assign a student to care for clients who have stress-related disorders, such as ulcers, cardiovascular disease, or hypertension.

4. Ask a student to volunteer to be put in a stressful situation such as answering questions for the health knowledge bowl. Record the student's blood pressure, pulse, respirations, and blood sugar before the oral exam begins. After ten minutes of constant questioning, monitor the student's vital signs again to see if they have changed.

5. Demonstrate relaxation techniques for relieving stress.

6. Develop a list of appropriate ways for the students to express emotions.

Audiovisual Supplements (available from MVRC):

On Top of Old Smoky. Videocassette. Carlocke/Langden, Inc., 1983. 15 min.

Activity Sheet Answers:

1. It is the body's response to the demands of life.

2. Answers will vary, but may include the following:
    a. Noise and heat
    b. Expecting to make an "A" on an exam
    c. Expecting a teenager to babysit younger siblings on the night of the homecoming game
    d. Getting married, buying a new home, meeting new people
    e. Divorce, loss of a job, and being in debt

3. a. Alarm phase - the body gears up to fight or flee the situation. The heart rate, respiratory rate, blood pressure, and metabolism increase. There is more sugar in the bloodstream and the pupils dilate.

    b. Resistance phase - the body adapts by trying to balance the need to work faster with some conservation measures to help it keep going.

    c. Exhaustion phase - the body shows signs of illness; the body takes control and "makes" the person sick so they are removed from the demand.

4. Answers should include three items from each category.

Figure 2.1 - Symptoms of Stress

a. PHYSICAL	b. EMOTIONAL	c. COGNITIVE	d. SOCIAL	e. SPIRITUAL
• nail-biting • tense muscles • restlessness • insomnia • problems with appetite, either loss or excess • stomachache • headache • problems with the bowel: diarrhea, constipation • frequent urination • dry mouth • sweaty palms and clammy skin • hyperventilation	• complaining • crying • anger • irritability • apathy • frustration • mood swings • depression	• confused • forgetful • daydreams • inability to problem-solve	• sullen • withdrawn • defensive • blames others • inability to relax	• purposeless • lack of sense of self-worth • thinks life is meaningless • lets go of values

5. Answers should include five of the following:
   - Follow healthy living practices: eat a balanced diet, get the proper amount of rest, and exercise regularly.
   - Practice relaxation techniques.
   - Allow yourself to express emotions in appropriate ways.
   - Resolve conflicts.
   - Indulge yourself on occasion.
   - Don't be afraid to say "no."
   - Use humor or go see a funny movie.
   - Don't "borrow" problems from the future; take one day at a time.
   - Allow yourself to daydream on breaks.
   - Use support systems to meet emotional, social, and physical needs.
   - Talk about your feelings with someone you trust.
   - Allow yourself to play.
   - Relabel a stressor or a problem as a challenge or a learning experience to readjust your outlook.
   - Whisper positive encouragement to yourself.

6. Answers should include three of the following:
   - Drinking alcohol
   - Smoking
   - Using over-the-counter or illegal drugs
   - Ignoring the stressor
   - Walking away from the situation

Answers to Written Unit Evaluation:

1. b
2. c
3. a
4. d
5. b
6. d
7. a
8. c
9. a
10. b
11. b
12. c
13. d
14. b
15. a
16. b
17. c
18. b
19. a
20. c
21. a
22. d
23. d
24. a
25. e
26. c
27. d
28. h
29. a
30. g
31. e
32. b
33. Answers should include three of the following:
    - Names and addresses of references
    - Copy of the resume
    - Driver's license
    - Social security card or green card
    - High school transcript
    - Competency sheets from nurse assistant training
    - Certificate of completion of training program

34. Answers should include one from each category.

Figure 2.1 - Symptoms of Stress

a. PHYSICAL	b. EMOTIONAL	c. COGNITIVE	d. SOCIAL	e. SPIRITUAL
• nail-biting • tense muscles • restlessness • insomnia • problems with appetite, either loss or excess • stomachache • headache • problems with the bowel: diarrhea, constipation • frequent urination • dry mouth • sweaty palms and clammy skin • hyperventilation	• complaining • crying • anger • irritability • apathy • frustration • mood swings • depression	• confused • forgetful • daydreams • inability to problem-solve	• sullen • withdrawn • defensive • blames others • inability to relax	• purposeless • lack of sense of self-worth • thinks life is meaningless • lets go of values

Unit III

Interpersonal Relationships and Communication Skills

Overview of the Unit

This unit discusses group dynamics in relation to working as a team. The interpersonal relationships between group members are described and the characteristics of quality health care providers identified. The client's role in interpersonal relationships is discussed, as well as unique characteristics of clients that the nurse assistant may encounter. The unit concludes with a discussion of communication skills as needed for reporting, charting, and reinforcing teaching.

Lesson 1: The Team Approach to Quality Health Care

Objectives:

1. Define a group, interpersonal relationships and group dynamics.
2. Describe the phases of a group.
3. Discuss the roles of members of a group.
4. Participate as a team member.
5. Discuss how clients and their families can be viewed as customers.
6. Identify characteristics of quality health care providers.
7. Provide quality health care.

Teaching Strategies:

1. Explain to the students that the class is a group. Have them think back to when the class first came together at the start of the school year. Ask them what happened in the initiation phase and what they are doing now in the working phase.

2. Have the students identify all the groups to which they belong. For example, most belong to the group known as a family. Some students belong to school clubs, and others participate in team sports. If the class has a VICA group, both the phases and the roles of the members can be identified.

3. Role-play different interpersonal relationships. Develop three types of encounters between health care workers and clients: a positive experience using therapeutic communication techniques to resolve a client complaint, a negative experience using non-therapeutic communication techniques, and a purely social interaction. After role-playing, each player should discuss how he or she felt about the interaction. The rest of the class may identify how the interaction helped to establish the relationship or to destroy the relationship.

4. Ask local business owners if they have guidelines for customer satisfaction. Share these with the class, and discuss how to apply the guidelines to health care clients as customers of the nurse assistant.

5. Ask a health care worker to speak to the class about client satisfaction and what the nurse assistant can do to increase the satisfaction of his or her clients.

6. Before discussing characteristics of quality health care providers, ask the class to list characteristics that they feel a health care provider should possess. Write the characteristics on the board. After the class has generated their list, compare it with the one in the lesson.

7. If the students go out to interview on their own, individual students may need to be assigned to certain facilities to prevent overloading one facility. When the students complete the clinical laboratory assignment, time should be given in class for them to discuss their findings and any differences between facilities.

Audiovisual Supplements (available from MVRC):

1. *Withering Heights*. Videocassette. Carlocke/Langden, Inc., 1983. 14 min.
2. *Communications: Peer Relationships*. Videocassette. Medcom, Inc., 1987. 17 min.

Activity Sheet Answers:

1. A group is a collection of two or more people.

2. An interpersonal relationship is a relationship that develops between people in a group.

3. An interpersonal relationship is any relationship that develops between two people. A therapeutic relationship is a special relationship between a health care worker and a client. In a therapeutic relationship, the client must be helped and made to feel better from any interaction.

4. Group dynamics is the way the members of a group interact.

5. a. Initiation phase - Relationships between the members of the group are determined. Goals and purposes of the group are identified. Each member of the group takes on a role.

   b. Working phase - The goals of the group are achieved using problem-solving.

   c. Termination phase - The group is disbanded after the task is completed; the group must summarize and should feel a sense of accomplishment.

6. The group leader is the person responsible for guiding the group and ensuring that the task of the group is completed.

7. A formal leader is the one who is designated as the leader by the group. An informal leader does not have the title of a leader but the group members turn to this person for guidance and help.

8. Answer should include three of the following:
    - Initiator - thinks of new ideas; keeps the group moving toward the goal
    - Information Seeker - tries to obtain the information the group needs; sees where information that the group has is lacking
    - Evaluator - evaluates the group's progress and checks to see if all group members agree
    - Coordinator - puts ideas together and builds on others' ideas
    - Procedural Technician - does routine tasks
    - Recorder - serves as secretary; keeps notes and communicates needs in writing

9. Answer should include three of the following:
    - Encourager - supports others; accepts group members as they are
    - Harmonizer - mediates; reconciles disagreements
    - Compromiser - attempts to bring opposing members together using a solution that is acceptable to both
    - Standard Setter - keeps group aware of norms
    - Gatekeeper - keeps track of time; makes sure all participate and are allowed to communicate
    - Tension Reducer - uses humor effectively; makes sure the group takes needed breaks

10. Answer should include three of the following:
    - Aggressor - attacks other members of the group or the group as a whole; takes credit for the group; belittles others
    - Blocker - has a negative attitude; stubbornly opposes everything; brings up old issues that the group has previously settled
    - Recognition Seeker - calls attention to self; boasts
    - Playboy/girl - makes fun of important issues; displays lack of interest
    - Dominator - very authoritative; interrupts; gives directions
    - Help Seeker - seeks sympathy from the group; needs help with tasks; "poor me"

11. Health care clients are people who are purchasing a service and have a right to expect that the service is of high quality. When clients are not satisfied, they may expect compensation, or go elsewhere to receive services.

12. Answer should include six of the following:
    - Dependable
    - Knows limits of the job role
    - Accurate
    - Able to follow directions
    - Conserves supplies
    - Flexible
    - Efficient
    - Trustworthy
    - Cooperative

- Courteous
- Even-tempered
- Keeps personal problems and private life to self
- Actively listens to others

Lesson 2: The Client as a Unique Individual

Objectives:

1. Discuss the diversity of clients.
2. Exhibit sensitivity to the diversity of others.
3. Describe defense mechanisms clients use to cope with their emotions.
4. Discuss challenging behaviors in clients and how to manage them.
5. Exhibit tolerance to challenging clients and/or families.
6. Describe clients' and/or families' reaction to loss.
7. Discuss techniques to use when working with a depressed client.
8. Exhibit sensitivity to clients' and/or families' pain and loss.

Teaching Strategies:

1. Each student could research a different culture, then present the information in class.

2. Have someone from a different cultural background than the students speak to the class about his or her culture.

3. Obtain a copy of the requirements for the employment of the disabled and discuss it in class.

4. Have students role-play being clients using defense mechanisms and challenging behaviors and being nurse assistants who must interact with them. If possible, videotape the activity.

5. Cultural sensitivity training programs have materials to simulate how it feels to be different. Gender equity materials that address the issue of discrimination can be obtained through the Project SERVE or the Gender Equity coordinator at the Department of Elementary and Secondary Education.

Audiovisual Supplements (available at MVRC):

1. *Respecting Yourself and Others*. Videocassette. PeaceTalks—Violence Prevention Video Series, Live Wire Media, 1997. 30 min.
2. *Bridging Racial Divisions*. Videocassette. PeaceTalks—Violence Prevention Video Series, Live Wire Media, 1997. 30 min.

Activity Sheet Answers:

1. Client diversity may be related to the client's age, disability, culture, religion, or economic status.

2. A prejudice is an attitude, opinion, or feeling about someone or something that is based upon preconceived ideas or supposed characteristics. It blinds the prejudiced individual to the true nature of clients.

3. a. Denial
   b. Rationalization
   c. Projection
   d. Displacement
   e. Suppression
   f. Fantasy

4. a. Anxiety - Anxiety can be managed by being reassuring and supportive. The nurse assistant must give clients as much information as possible about procedures and reinforce any teaching given by a health professional. Clients feel less anxious when they feel they have control over daily activities.

   b. Overdependence - Overdependence is managed by encouraging the client to do as much as possible for himself or herself. Positive feedback should be given when the client accomplishes even a small task.

   c. Demanding - The demanding client is managed by giving him or her control whenever possible. Gain trust by always doing what you have promised. Being consistent in the daily routine also reassures the client, builds trust, and helps to decrease demanding behavior.

   d. Agitation - The nurse assistant must stay calm. Obtain help if you fear for your personal safety. Try setting limits on behavior by telling the client what is acceptable. Provide a substitute object that the client can hit to relieve the frustration causing the agitation. Never argue or confront the client. Remove items that are safety hazards from the environment to keep the client and health care workers safe. Avoid known triggers for agitated behavior.

5. Answer should include six of the following:
   - Feeling sad and hopeless
   - Poor appetite
   - Difficulty sleeping
   - Fatigue
   - Headaches
   - General weakness
   - Apathy
   - Not interested in environment
   - Suicidal thoughts

6. Answer should include three of the following:
   - Do not try to talk the depressed client out of his or her depression.
   - Use active listening.
   - Encourage use of support systems.
   - Give positive feedback.
   - Keep the client active with simple activities.
   - Maintain a positive attitude around the client.

Lesson 3: Communication Skills

Objectives:

1. Provide information about the client to the nurse in charge.
2. Communicate pertinent information at the shift change.
3. Chart observations and procedures.
4. Recognize and report incidents.
5. Complete incident reports.
6. Reinforce client teaching identified in the plan of care.
7. Identify how computers are used in health care.
8. Maintain client confidentiality.

Teaching Strategies:

1. Provide a list of observations to the students and have the students identify whether they are objective or subjective observations.

2. Obtain copies of a flow sheet, Resident Assessment Instrument, Minimum Data Set, charting documents, and incident reports from local health care facilities to show the class. Transparencies of charting documents are useful for demonstrating how to record information.

3. Demonstrate how to give a change of shift report.

4. Do a simple client teaching activity, such as giving instructions about how to take medications, expected effects, and side effects to watch for when dismissed from the hospital. Divide the students into pairs. One student will play the role of the client and the other the role of the nurse assistant. The client should ask questions about the information provided, and the nurse assistant should reinforce the teaching.

5. Visit a health care facility that uses computers to keep client records. Ask someone from the nursing department or the medical records department (whichever is appropriate to the situation) to discuss pros and cons of computer use in health care settings.

6. Ask a health care worker to speak to the class about computer use in his or her facility.

Audiovisual Supplements (available from MVRC):

1. *Well Shut My Mouth*. Videocassette. Carlocke/Landen, Inc., 1989. 12 min.
2. *Abnormal Signs and Symptoms*. Videocassette. The Nursing Assistant Series, Medcom, Inc., 1990. 10 min.
3. *Communication Skills*. Videocassette. Medcom, Inc., 1987. 31 min.
4. *Communication: The Process*. Videocassette. Medcom, Inc., 1987. 25 min.
5. *Confidentiality - Legal and Ethical Concerns*. Videocassette. Medcom, Inc., 1996. 25 min.

Activity Sheet Answers:

1. Answers will vary and should contain objective observations that express facts gathered using one's senses.

2. Answers will vary and should contain subjective observations that express opinions about the client.

3. An initial assessment is the information gathered when a client enters a health care facility.

4. a. Acute care - initial assessment sheet, flow sheet, and narrative charting sheet
   b. Long-term care - Resident Assessment Instrument, Minimum Data Set, flow sheet, and narrative charting sheet
   c. Home health care - combination checklist and narrative document, time log of activities and nursing care

5. a. Who - the person in charge of care for the client
   b. What - any observations of status changes; care and procedures completed and those left incomplete and the reason for non-completion; physical, mental, emotional, or social changes; complaints or questions; and routine physiological functions
   c. When - depends on importance; immediate reporting for injuries, changes in client's condition, and complaints

6. One health care team transfers information to another in the change of shift report to ensure that client care is continuous. The home health aide provides information about the client's likes and dislikes and the best way to complete procedures to the person who is taking over the care.

7. It is assumed that the client's care and/or treatments were not done.

8. An incident is any act or situation that occurs in which the client is injured, has a potential for injury, or has legal implications. The information reported is general information about the person(s) involved, a factual account of what happened, injuries sustained by the person(s) and treatment given, and any witnesses with their addresses and phone numbers.

9. Answers should include three of the following:
    - Make sure the client is focused on the person giving the information.
    - Use examples of how the information will help the client.
    - Make sure you understand the information before trying to assist the client.
    - Use language the client will understand. Health care workers sometimes use medical terminology that the client does not know.
    - Give information slowly and in small segments.
    - Remember that the client may need information repeated often before they understand it. Teaching takes patience.
    - Allow time for teaching at a relaxed pace and for the client to ask questions.

10. Answers should include three of the following:
    - Keep records and financial accounts.
    - Record client information.
    - Access client information.
    - Order tests and procedures
    - Generate reports, inventory and order supplies.
    - Provide information about policies, procedures, and medications.

11. The nurse assistant must protect the client's privacy. Do not discuss clients and their care in public areas. Do not discuss health care work with family, friends, neighbors, or anyone who asks about specific clients. Information on computers should be accessed only for those clients for whom direct care is being given.

Answers to Written Unit Evaluation:

1. b
2. d
3. c
4. a
5. c
6. b
7. b
8. d
9. c
10. a
11. d
12. b
13. a
14. c
15. d
16. a
17. b
18. c
19. c
20. d
21. b
22. a
23. c
24. a
25. e
26. a
27. g
28. d
29. h
30. c
31. f
32. m
33. b
34. j
35. g
36. o
37. k
38. d
39. i
40. a
41. n
42. h
43. e
44. b
45. h
46. c
47. a
48. e

49. Answers should include two of the following:
    - Dependable
    - Knows limits of the job role
    - Accurate
    - Able to follow directions
    - Conserves supplies
    - Flexible
    - Efficient
    - Trustworthy
    - Cooperative
    - Courteous
    - Even-tempered
    - Keeps personal problems and private life to self
    - Actively listens to others

Unit IV

Safety

Overview of the Unit

This unit discusses safety. General guidelines for safety and safety issues specific to the home are presented. Included in the unit are lessons on infection control and crisis intervention.

Lesson 1: Guidelines for Safety

Objectives:

1. Identify OSHA safety standards.
2. Identify general guidelines for worker safety.
3. Describe hazards found in the health care industry.
4. Identify the components of a good safety program.
5. Describe risk management in a safety program.
6. Follow OSHA guidelines.

Teaching Strategies:

1. OSHA provides educational safety materials. Contact the local or regional office for available materials. Speakers may also be available in your area to give presentations on safety issues.

2. A risk management employee from a local health care facility may also be available to speak to the class about hazard prevention.

3. A representative from a local health care facility may be willing to present the safety material used during employee orientation.

4. Have students investigate the school for potential safety hazards. After discussing the safety hazards in class, students should develop a list of hazards that they have found and present the list to the school administrator.

5. Choose a spokesperson for the class to go to the school principal or building administrator and ask what the safety guidelines are for the building. Try to obtain a copy of the safety policies. Bring the information back to the class for discussion. Make suggestions regarding changes in the policies that would improve the safety of the students.

6. Find out if the school district has a risk management department or person. Choose a student representative from the class to interview that person and find out what the most important safety issues are for the school.

Audiovisual Supplements (available from MVRC):

1. *Minimizing Back Strain on the Job.* Videocassette. Tel-A-Train, 1995. 24 min.
2. *A Bit About Backs: Back Basics.* Comprehensive Loss Management, Inc., 1993. Videocassette. 13 min.
3. *A Bit About Backs: Risk Factors.* Videocassette. Comprehensive Loss Management, Inc., 1993. 14 min.
4. *A Bit About Backs: Prevention Strategies.* Videocassette. Comprehensive Loss Management, Inc., 1993. 15 min.
5. *What Happened?* Videocassette. Carlocke/Langden, Inc., 1983. 12 min.

Activity Sheet Answers:

1. OSHA

2. a. Limits of exposure to dangerous substances
   b. Safety programs that institutions must provide for their workers
   c. Conditions and procedures the institutions must maintain

3. a. Wear protective equipment when working around chemicals or infectious agents.
   b. Report hazardous conditions to the supervisor.
   c. If the hazard is not corrected after a reasonable length of time, follow the chain of command until someone acts to correct the hazard.
   d. Contact the local OSHA office if the institution has not corrected the hazard.
   e. Refuse to work when faced with imminent danger of death or serious injury from a hazard in the workplace.

4. a. Biological/infectious hazards - involve infectious agents transmitted by contact with infected clients or contaminated bodily secretions (e.g., hepatitis, HIV, tuberculosis, and lice)

   b. Chemical hazards - caused by chemicals that are potentially toxic or irritating to a body system (e.g., cleaning solutions, sterilizing agents, drugs, and latex gloves)

   c. Environmental/mechanical hazards - factors in the work environment that can cause accidents, injuries, strain, or discomfort (e.g., unsafe equipment, poor air quality, and cluttered work areas)

   d. Ergonomic hazards - related to the design or modification of a workplace to match human characteristics and capabilities (e.g., high beds, awkwardly placed handrails, and low chairs)

   e. Physical hazards - agents in the work environment that can cause tissue trauma (e.g., combative clients, cold/heat, fire, electrical shock, radiation, sharp objects)

   f. Psychosocial hazards - factors or situations that may cause stress, emotional strain, and/or interpersonal problems (e.g., aggression and violence by clients, varying shift work, and high-pressure assignments)

5. a. Management
   b. Leadership
   c. Employee participation

6. A risk management department or employee is responsible for the collection and analysis of data about accidents, injuries, and illnesses. The incident report may be filed with this department or employee.

Lesson 2: Home Safety Issues

Objectives:

1. Identify home safety concerns and potential hazards to the client in the home.
2. Respond appropriately to hazards and home safety concerns.
3. Describe possible emergencies that may occur in the home.
4. Identify appropriate actions to take during emergencies in the home.
5. Describe possible emergencies that may occur in the community.
6. Respond appropriately to community emergencies.
7. Review the home safety plan with the client and others providing care in the home.
8. Carry out the home safety plan if an emergency occurs during the home visit.

Teaching Strategies:

1. Bring various cleaning solutions to class so students can examine the labels. Identify antidotes discussed in product packaging.

2. Have students investigate the safety hazards and poisons in their own homes. Discuss in class what they have found.

3. Have a student represent the class and call the local health department to find out the location of the closest poison control center. The student should also ask if they have any literature on poison control. Discuss the information.

4. You may be able to obtain educational materials or find a guest speaker by contacting the local poison control hotline.

5. Contact the local fire department to ask if someone could talk to the class about additional information regarding fire safety in the home. Also, ask for a demonstration on the use of fire extinguishers. If possible, have them set a fire in a 50-gallon drum or a wastepaper basket so students may practice putting out a fire with a fire extinguisher. The local fire department may also provide audiovisual materials on safety.

6. Bring smoke detectors to class and have the students practice changing the batteries. Either light a match near one of the detectors or press the test button so students can hear the warning sound.

7. Develop an emergency evacuation plan for the classroom, and discuss the school's safety plan for tornados, earthquakes, and floods.

8. Have a student represent the class and call city hall to talk to the emergency preparedness department about your city's disaster plan. Discuss the plan in class.

9. Make a list of emergency phone numbers for your community to give to the students. As a service project, students could create and distribute a handout of emergency phone numbers.

Activity Sheet Answers:

1. Answers should include six of the following:

   - Identify a method of communication with one's supervisor if no telephone is available.
   - Carry a list of emergency numbers and post a list near the telephone if one is available.
   - Do not attempt to utilize a piece of equipment if you are unsure how to operate it.
   - Do not attempt to change fuses or throw circuit breakers unless you are familiar with these procedures.
   - Read the label of a substance before using it; do not use any unlabeled substances.
   - When caring for a child, close and lock (or guard) doors to stairways and the kitchen.
   - Keep Venetian blind cords out of reach of children.
   - With the client's permission, put all poisons in a locked, secure place.
   - Check the hot water temperature in all taps because the temperature setting may need to be lowered to prevent burns to young children or the aged whose skin is more sensitive; a temperature of 120 degrees Fahrenheit is the maximum setting for safety.
   - Check smoke detectors routinely to be sure they are functioning; if none are present, suggest that the client install them.

2. Answers should include one of the following in each category:

   a. Living room -
      - Obstructed pathways can be cleared by rearranging the furniture.
      - Unstable furniture can be moved against the wall.
      - Furniture with sharp edges can be moved out of the way.
      - Small objects can be moved out of the way.
      - Electrical cords could be moved to pass behind furniture.
      - Carpeting should be in good condition.

   b. Kitchen -
      - Food should not be left unattended in the oven or on the stove.
      - Flammable items should be kept away from the stove.
      - If the client has a pacemaker and a microwave oven is utilized during cooking, the client should stay out of the immediate area.
      - Floors should be kept free of spills and debris.
      - Tile and linoleum floors should be left unwaxed.
      - Drawers and cabinet doors should be kept closed.

- An all-purpose fire extinguisher should be kept in the kitchen.
- Store items that are used frequently within easy reach to reduce climbing or bending.
- Electrical appliances and cords should be placed away from the edge of counters and the sink.
- Cleaning solutions should be stored away from food storage areas in a location that is either kept locked or is not easily accessible.

c. Bathroom -
- Care should be taken to keep water off the floor during personal hygiene tasks.
- If water is spilled or dropped on the floor, it should be wiped up immediately.
- The home health aide may suggest purchasing a secure bath mat for the floor and non-skid rubber decals or strips for the tub or shower.
- If the client needs the support of a bar when getting out of the tub or shower or up from the toilet, the aide may recommend that special grab bars be installed.
- He or she may also suggest that a raised toilet seat be installed if the client has difficulty sitting down on and rising from one at a standard height.
- If the client cannot get in and out of the tub safely, a tub chair or bench may be recommended for his or her use.
- Bathing can make the client weak; if the client gives his or her permission, placing a chair in the bathroom allows the client to sit down if he or she becomes weak while taking care of personal hygiene needs.
- With the client's consent, breakables such as drinking glasses and ceramic toothbrush holders should be removed from the bathroom to prevent the possibility of cuts.
- The faucets should be correctly marked for hot and cold water.
- Electric appliances should not be used in the bathroom.

d. Bedroom -
- The home health aide should suggest that the bed be about knee height to allow the client to get in and out easily.
- The pathway to the door should be kept clear of obstacles.
- The aide might recommend that a night-light be used.
- A bedpan or commode can be kept at the bedside for nighttime use.
- The home health aide should check the client's clothing for any loose areas that might catch on doorknobs or other objects; slippers should be checked to make sure they fit properly to prevent falls.
- The aide should keep drawers and doors to chests, dressers, and closets closed.

e. Outside the house -
- The client should always make use of handrails if one is available.
- The home health aide can suggest that all steps be clearly marked with a stripe of contrasting paint on the edge of the step to help the client identify where the step is.
- If available, supportive walking shoes with nonslip soles and walking aids, such as canes and walkers, should always be used by the client.
- The aide may recommend that the client avoid going out at night, since potential dangers are not as easily seen in the dark.

- Trips outside should be postponed in inclement weather, since walking surfaces will be slippery.

3. Answers should include two of the following:

   - No candles or open flames, such as a fireplace, should be used.
   - Use care in combing the client's hair since static electricity is sometimes generated.
   - Check with the oxygen distributor for instructions on how to work and maintain the oxygen system.
   - A system should be developed to coil and uncoil the trailing oxygen tubing so the client does not trip and so the tubing is out of the way when not in use.

4. Notify the supervisor immediately. If the substance ingested can be identified, the poison control center can perscribe the antidote, which will counteract the effect of the poison in the body.

5. a. If the home has a fire extinguisher, the home health aide should know what type it is and how to use it. If an improper fire extinguisher is used, the fire may be spread rather than extinguished.
   b. When evacuating the home during a fire, always check to see whether a closed door is warm before opening it during a fire. If it is hot, the door should remain closed and another route taken.
   c. Electrical equipment, such as a stair lift, should not be used during a fire.
   d. When evacuating the home, the aide and residents should close doors to contain the fire as much as possible.
   e. Neither the aide nor the client should enter a room in which evidence of a fire exists. Fire spreads very rapidly, often within a few minutes.
   f. If fire traps the aide and the client in a room, they should keep the door closed and roll up a blanket or a rug to place along the bottom of the door. They should then open a window and attract the attention of rescuers.

6. Inform local authorities that clients may need to be moved from the area sooner than other residents because access to medications, tanks of oxygen, food, electricity, or other substances upon which they depend may be cut off by the flood waters. Discuss plans with clients and others regarding where they might go and how they would get there. Inform the home health agency and all others involved in the care of the clients of any residence changes of during an emergency.

7. If the home health aide is in a client's home when a tremor occurs, he or she should see that the client is protected from falling objects. If the earthquake is severe, the aide should move the client outside, away from buildings that might collapse and power lines that might fall. If the earthquake is severe enough to disrupt power and water supplies, the home health aide should stay with the client and follow the guidelines of the agency's or community's disaster plan.

8. If tornado sirens sound while the home health aide is caring for a client, he or she should move the client to a safe area in the house. The aide should remain with the client until the all-clear signal sounds. If the tornado strikes the home, and the client is injured,

basic first aid measures should be performed and the client should be kept comfortable until assistance arrives.

9. A home safety plan is a plan establishing what each person in the home will do if an emergency, such as a fire or natural disaster, occurs.

Lesson 3: Infection Control

Objectives:

1. Identify infectious diseases currently affecting nursing.
2. Differentiate between types of isolation precautions.
3. Apply CDC isolation precautions to client situations.
4. Adapt infection control procedures to limitations in the home.

Teaching Strategies:

1. Divide the class into groups of four or five, and assign each group an infectious disease to research. Have the groups present their findings to the rest of the class.

2. Ask local health care facilities if an infection control nurse is on staff. If available, ask the nurse to present information on infection control to the class. A representative from the local health department may also be asked to speak to the class.

3. Provide students with a waterless antiseptic solution to use on their hands. Discuss whether students think their hands feel as clean with the antiseptic solution as they do after washing with running water and soap.

4. Have the students practice putting on and removing infection control equipment such as gowns, masks, gloves, and goggles.

5. If the students are at the clinical site, they should observe how the staff manages the clients who have transmission-based precautions.

6. Contact the local health department for a copy of the policies on medical waste disposal in the home. Share the information with the class.

7. Put together a kit of supplies for the home health aide to take into the home. The kit should include everything the home health aide would need to practice standard precautions on a client who is incontinent of urine and stool.

Audiovisual Supplements (available from MVRC):

1. *Infection Control Techniques.* Videocassette. CA Medcom, Inc., 1990. 15 min.
2. *Don't Bug Me.* Videocassette. Carlocke/Langdon, Inc., 1983. 14 min.
3. *Tuberculosis: Prevention and Practices for Health Care Workers.* Videocassette. CA Medcom, Inc., 1993. 22 min.

4. *Universal Precautions - AIDS and Hepatitis Prevention for Healthcare Workers.* Videocassette. CA Medcom, Inc., 1997. 34 min.

Activity Sheet Answers:

1. Nosocomial infections are infections acquired in a health care facility.

2. a. HIV - a virus that attacks cells in the body and eventually impairs the body's immune system. The virus is spread by contact with infected blood or other bodily fluids.

    b. Hepatitis B - an infectious contagious disease of the liver caused by a virus found in the body fluids of an infected person that produces flu-like symptoms.

    c. Tuberculosis - an infectious bacterial disease spread by airborne droplets when an infected person coughs, sneezes, or laughs. The organism implants itself in the lung, causing inflammation. The infected person develops a cough, dyspnea, general malaise, a low-grade fever, and night sweats.

    d. Pneumonia - inflammation of the alveoli of the lungs caused by organisms that can be bacterial, viral, or fungal in nature. The infection affects infants and the elderly most often, generally in the winter and early spring. The symptoms are a cough with green or rust-colored sputum; rapid, shallow respiration; fever; chills; chest pain; and general malaise.

3. Multidrug-resistant - organisms that have developed a resistance to many different antibiotics.

4. Standard precautions are isolation procedures that should be used with every client whether or not an infectious organism has been identified; every client is treated as if he or she were potentially infectious.

5. Hands must be washed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; before donning gloves; after gloves are removed; between client contacts; and between tasks and procedures on the same client.

6. Gloves must be worn when touching blood, body fluids, secretions, excretions, and contaminated items and before touching mucous membranes and broken skin.

7. A mask, eye protection, or a face shield must be worn during procedures that can cause splashes or sprays of blood, body fluids, secretions, and excretions. Gowns must be worn during procedures or situations where there may be exposure to blood, body fluids, secretions, or excretions are present.

8. When transporting any client, appropriate precautions must be taken to minimize the risk of infection to other clients, personnel, visitors, environmental surfaces and equipment.

9. Client care equipment must be adequately cleaned and disinfected after use or whenever it becomes soiled with blood, body fluids, secretions, and excretions. Disposable, single-use equipment should be discarded properly and immediately.

10. Transmission-based precautions are isolation procedures used for clients that are known to be infected or for those suspected of having an infection.

11. a. Airborne precautions - used when the infectious agent is carried in the air and can be inhaled. Airborne precautions would be used for tuberculosis.

    b. Droplet precautions - used when the infectious agent is transmitted in droplets (through sneezing, for example) to the mucous membranes of another person

    c. Contact precautions - used when the infectious agent is transmitted either directly (through body to body contact) or indirectly (through an intermediate object)

12. Answers should include four of the following:

    - Cloth towels that are used by the client and others in the home will carry microorganisms and should not be used by the home health aide.
    - Bar soap usually sits in soapy residue that can be a breeding ground for microorganisms, so liquid soap is preferable for handwashing.
    - If running water is not available in the home, the home health aide should carry a waterless antiseptic agent to be used in place of the handwashing procedure.
    - Gloves should be part of the standard equipment that is carried by the home health aide.
    - If the client has an infection, personal protective equipment should be provided by the home health agency.
    - Body waste products should be flushed down the toilet as soon as possible.
    - Spills of body fluids or blood should be cleaned up by a person wearing gloves. The area should be wiped with a solution of one part household bleach to 10 parts water. The rag should be thrown out.
    - Sharp objects such as needles should be placed in a puncture-resistant container. A coffee can with a plastic lid works well for this purpose. Some items may need to be disposed of immediately; others can be accumulated until the can is full. Check with the supervisor to determine the procedure for disposal of such objects.
    - Dressings should be placed in a plastic bag. If they are regulated medical waste, they must be double-bagged for disposal and/or transport.
    - Unsoiled laundry does not need special attention. Soiled laundry should be handled with gloves and kept separate from the other laundry. If the soiled laundry cannot be cleaned immediately or must be transported out of the home, it should be double bagged in plastic. The contents of the double bags should be emptied into the washer without handling the items, and the plastic bags should be thrown away.
    - If disinfectant solutions are needed to clean equipment, the cleaning solution should be disposed of by flushing it down the toilet.

Lesson 4: Crisis Intervention

Objectives:

1. Identify types of crises the nurse assistant may encounter.
2. Describe crisis intervention techniques.
3. Identify hazards to personal safety.
4. Use physical crisis intervention techniques.

Teaching Strategies:

1. Use classroom discussion to share crises the students have encountered.

2. Have students list hazards to personal safety that they have identified at the local shopping center, at school, and at the movie theater.

3. Find a crisis intervention counselor at a local mental health facility or hospital mental health unit who could speak to the class.

Audiovisual Supplements (available from MVRC):

1. *Preventing Violence.* Videocassette. PeaceTalks--Violence Prevention Video Series, CA LiveWire Media, 1997. 30 min.
2. *Dealing with Bullies, Troublemakers, and Dangerous Situations.* Videocassette. PeaceTalks--Violence Prevention Video Series, CA LiveWire Media, 1997. 30 min.
3. *Drugs, Alcohol, and Guns - Triggers to Violence.* Videocassette. PeaceTalks--Violence Prevention Video Series, CA LiveWire Media, 1997. 30 min.

Activity Sheet Answers:

1. A crisis is a significant moment or event in a person's life or during an illness that has an emotional or physical effect on the individual.

2. a. Developmental crisis - a crisis directly related to a stage in a person's life. People's lifestyles change as they age. With each change, new decisions must be made and different emotions managed. Examples of such changes are graduation from high school, marriage, and aging.

   b. Situational crisis - a crisis precipitated by an extremely stressful event that can occur at any point in a person's life. These crises can be caused by illness, death, a traumatic accident, divorce or loss of a job.

3. Crisis intervention is when a health care worker steps into a situation with the intention of resolving an immediate problem. The intent of the intervention is to decrease the stress produced by a sudden event and to identify resources to assist the client in coping with the situation.

4. a. Ask what is wrong.
   b. If the crisis is an emergency, carry out emergency first aide measures and call for assistance. If the crisis is not an emergency, determine whether you have the necessary skills to handle the crisis or if you need to contact the supervisor.
   c. Identify solutions to the problem, consulting with the client and others.
   d. Implement the best solution to resolve the crisis.
   e. Evaluate the solution by observing the behavior of the client to determine if the stress has been relieved.

5. Answers should include three of the following:

   - Health care workers encounter hazards to their personal safety because of their close interaction with the public, not only the clients, but the clients' families and other visitors.
   - If the nurse assistant is working in a hospital, people usually have unrestricted access to these facilities.
   - People are aware of the availability of drugs, needles, and other health care supplies in health care facilities, which makes them a prime target for anyone seeking such substances.
   - Health care workers work late evenings, throughout the night, and during the early morning; usually with reduced staff during those hours.
   - Health care workers, such as home health aides, may also work alone and in areas of high crime or rural isolation.
   - Because people who are ill sometimes lose their ability to cope with their situation, and may exhibit violent behavior.

6. Answers should include two of the following:

   - Staying in areas with good lighting, avoiding threatening situations, such as stairwells or scarcely populated elevators when the nurse assistant is working alone, late at night, or in an area where there is potential danger.
   - The buddy system can be used if another person is available so that neither person has to enter an area alone.
   - If a situation appears threatening, immediately leave the area and request assistance.
   - If the nurse assistant is working alone in an area with a high crime rate or an isolated rural area, a daily work plan should be on file, and clients should be instructed to call the agency if the worker does not show up as planned.

Answers to Written Unit Evaluation:

1. d
2. a
3. c
4. b
5. d
6. b
7. c
8. b
9. a
10. d
11. b
12. c
13. b
14. a
15. c
16. b
17. d
18. c
19. d
20. a
21. b
22. c
23. a
24. b
25. e
26. c
27. b
28. a
29. f
30. d
31. b
32. c
33. g
34. a
35. f
36. e

Unit V

Personal Care

Overview of the Unit

This unit contains all the personal care activities that the nurse assistant must do for clients to complete the activities of daily living. The lessons include an introduction to personal care: eyeglasses, hearing aids, and prostheses; dressing and undressing; bathing; shaving; hair care; oral hygiene; nail care; perineal care; backrub/skin care; bedmaking; and the client's environment.

Lesson 1: Introduction to Personal Care

Objectives:

1. Identify activities that make up personal care.
2. Discuss the general considerations in providing personal care.
3. Describe how to plan personal care activities.
4. Determine which clients require assistance with personal care activities.
5. Identify adaptive measures that may be necessary when giving personal care to clients with special conditions.

Teaching Strategies:

1. Have the students record personal care activities that they do each morning and at what time these are done. Compare the activities and times from one student to another. Discuss how students would feel if they were forced to change the order and/or times these personal care activites were done. Make the comparison to clients who wish to have their care done in a time and manner that matches their personal preferences as much as possible.

2. Obtain a schedule of meals and activities from a local long-term care facility. List personal care items that must be done for several clients. Have the students draw up a time line around meals and activities for when all care will be done.

3. Show the students examples of personal care equipment that might be found in health care facilities, such as basins, soap, linen, client gowns, shavers, emery boards, and lotions.

4. Have the students role-play someone with hemiparesis and paraplegia and practice dressing each other in a client gown and scrub pants.

5. Assign students who are on the clinical unit to care for a client with hemiparesis, diabetes, or arthritis. Students should share their experiences and feelings about providing care when they return to class.

Audiovisual Supplements (available from MVRC):

1. *Techniques in Personal Care.* Videocassette. The Nursing Assistant Series, CA Medcom, Inc., 1990. 22 min.
2. *Understanding Diabetes.* Videocassette. Missouri Quality Training Specialists Inc., 1991. 10 min.

Activity Sheet Answers:

1. Answers should include five of the following:
   - Eyeglasses, hearing aids and protheses
   - Dressing/undressing
   - Bathing
   - Shaving
   - Hair care
   - Oral hygiene
   - Nail care
   - Perineal care
   - Backrub/Skin care
   - Applying cosmetics
   - Bedmaking
   - Client's environment

2. a. Personal care activities - activities that involve caring for the human body and are a part of the activities of daily living
   b. Activities of daily living - activities done on a daily basis as part of life

3. a. Helps the client maintain a positive self-image
   b. Supports the client's good health

4. Answers should include six of the following:
   - Discuss personal care routines and preferences with each client.
   - Encourage clients to be as independent as possible by doing as much of their personal care as their strength or ability allows.
   - Wash your hands before and after any procedure.
   - Greet the client by name and introduce yourself.
   - Use only the client's own personal care equipment.
   - Give a thorough explanation of the procedure.
   - Use good body mechanics.
   - Remember safety factors to protect yourself and the client.
   - Personal care should be done in private.
   - Provide warmth if the client has to be undressed for the procedure.
   - Be confident, matter-of-fact and avoid verbal or nonverbal signs of distaste.
   - Obtain information about the client's physical and emotional condition while performing personal care.
   - Make observations about the client and keep notes for things to report.

5. Answers should include four of the following:
   - Know what the client can accomplish.
   - Be flexible as to the time it takes to do a procedure.
   - Know clients' routine activities which come at set times, such as meals and therapy.
   - Allow driving time when working in home health.
   - Gather supplies prior to the personal care procedure.
   - Distribute supplies to as many clients as possible at one time.
   - Place equipment and supplies where they can be easily reached.
   - Clean supplies and equipment and put them away as soon as the procedure is completed.

6. Answers should include two of the following:
   - You will be told by the supervisor.
   - Observe the clients.
   - Unconscious or unaware clients will require complete assistance.
   - Clients on bed rest will be limited in what they can do.
   - Clients with physical limitations may need help.

7. Answers should include two considerations for each of the following conditions of clients:
   a. Client who is unconscious
   - Explain procedures as if the client can hear everything that is said.
   - Gain assistance in lifting and moving the clients.
   - Keep the body in proper alignment.
   - Place the client on his or her side when all care has been completed.
   - Do care of the skin and perineum if incontinence is present.

   b. Client with paralysis
   - Handle the affected side or extremities with care, supporting the joints.
   - Position the affected extremities to maintain good circulation.
   - Avoid using the terms "good side" and "bad side."
   - Use techniques being taught to the client for self-care.
   - Support the client by assisting the client in his or her own personal routines.

   c. Client who has diabetes
   - Provide good skin care.
   - Check clothes and shoes to make sure that they do not impair the circulation or rub the skin.
   - Check the feet and legs for any changes.
   - Watch the skin for wounds or infections as diabetics do not always have any sensation in nerve endings.

   d. Client who has arthritis
   - Encourage the client to participate in personal care.
   - Allow a longer period of time as the client may move more slowly.
   - Do not force the joint beyond its range of motion.
   - Allow periods of activity alternated with periods of rest.
   - Allow for irritability caused by pain.
   - If available, use adaptive devices to assist the client.

   e. Client experiencing pain
   - Delay personal care activities until the client has been given or has taken pain medication.
   - Give complete assistance when needed.

- Distract clients from their pain by conversing with them during personal care activities.
- Do procedures at a pace that does not increase pain.
- Give rest periods.
- Notify the supervisor if the client cannot complete the personal care activities independently or with assistance because of the pain.

Lesson 2: Eyeglasses, Hearing Aids and Prostheses

Objectives:

1. Describe types of hearing aids.
2. Maintain hearing aids.
3. Insert and remove a hearing aid.
4. Maintain eyeglasses.
5. Place and remove eyeglasses.
6. Describe types of prostheses and their proper care.

Teaching Strategies:

1. Contact the administrator of a local long-term care facility to see if he or she can donate abandoned hearing aids or eyeglasses for demonstration purposes. A local hearing aid or eyeglass shop may also have old items or would be willing to save old items for demonstration use in the classroom.

2. If no hearing aids are available, purchase several hearing aid batteries so that students can see how small and difficult they are to manipulate.

3. A local eyeglass shop and/or hearing aid dispenser may have someone who is willing to come to the classroom to discuss types of devices and their care.

4. The physical therapy or occupational therapy department of a local hospital may have old prostheses that they would be willing to share for demonstrations in the classroom. If they do not have any examples of prostheses, ask if a therapist could discuss the care of different types of prostheses to the class.

5. Assign students who are on the clinical unit to work with a client who has glasses, hearing aids, or both. Finding a client with a prosthesis may be more difficult. If you or your students know someone in the community with a prosthesis, he or she may be willing to discuss how the prosthesis works and its care.

6. To simulate what it is like to see through dirty eyeglasses, buy a pair of nonprescription eyeglasses at the local drug store. Finger the glass and flick it with dirty water, letting the water dry. Have the students wear the glasses for about five minutes during class. After all the students have had a chance to wear the glasses, discuss their feelings.

7. Simulate hearing loss by having the students place cotton or ear plugs in their ears and by placing a pair of earmuffs or stereo earphones over the students ears. The instructor should then speak in a soft voice while lecturing. After all the students have had the experience, discuss their feelings.

Audiovisual Supplement (available from MVRC):

Techniques in Personal Care. Videocassette. The Nursing Assistant Series, CA Medcom, Inc., 1990. 22 min. *(A part of the video is about care of eyeglasses and hearing aids.)*

Activity Sheet Answers:

1. a. Intrauricular aids are worn in the ear.
   b. Behind the ear aids have a portion that fits in the ear and a channel that connects to a portion placed behind the ear.
   c. Eyeglass aids attach to the earpiece of a pair of eyeglasses.
   d. Body-worn aids have a piece placed in the ear that is connected by a cord to a sound amplifier that looks like a small radio or cassette recorder. The amplifier is placed in a pocket or clipped on a belt.

2. Answers should include two of the following:
   - Insert batteries correctly.
   - Turn off the hearing aid when it is not in the ear to conserve the batteries.
   - To turn off a hearing aid without an on/off switch, remove the batteries.
   - Store extra batteries in a cool, dry place.

3. The hearing aid is kept clean by wiping it with a clean, slightly damp cloth daily.

4. Answers should include four of the following:
   - Keep hearing aid away from excessive heat and cold.
   - Do not get hair spray, hair lotion, spray perfume, and shaving lotion on the hearing aid.
   - Do not insert sharp objects into any openings in the hearing aid other than the earmold.
   - Do not drop the hearing aid on a hard surface.
   - Do not twist or bend any tubing or wires.

5. Handle glasses by the frames. When not in use, glasses should be placed in a case. If a case is not available, place the glasses on the folded earpieces or on the frame, but NEVER on the lenses.

6. Glasses should be cleaned daily with either a mild soap and water or a special eyeglass-cleaning solution. Glasses should be dried with a clean, soft cloth.

7. A soft, damp cloth can be used to wipe the prosthesis to keep it clean.

8. Substances that could stain or mark the prosthesis, such as indelible pens, bleach, and paint, should be kept away from the prosthesis.

9. The skin of the stump of the extremity should be observed for any redness or irritation.

10. The nurse assistant should contact the supervisor for assistance if he or she does not know how to apply the prosthesis.

Lesson 3: Dressing and Undressing

Objectives:

1. Discuss the general considerations when dressing and undressing clients.
2. Assist clients to dress.
3. Assist clients to undress.

Teaching Strategies:

1. If possible, obtain adapted clothing with fasteners made of nylon tape. The occupational therapy department may have some of these items.

2. Obtain a lap robe from a local long-term care facility. Show students how to use the lap robe by placing it on a student seated in a wheelchair.

3. The occupational therapy and/or physical therapy departments may have adaptive equipment used to assist paralyzed clients with dressing and undressing. Check with the OT and PT departments for a possible loan of that equipment or if someone in the department could come and speak to the class about dressing/undressing techniques.

4. Demonstrate the procedures and allow time for the students to practice in the lab. Students can wear bathing suits to practice these procedures. Students could also practice placing bras on practice mannikins.

5. The students should have some practice in the lab before attempting to dress or undress clients in the clinical setting. If possible, assign students to clients who have a weak or paralyzed side so that they can experience dressing/undressing these types of clients.

6. Students can assume the roles of a hemiplegic so their partner can practice dressing and undressing that type of client.

Activity Sheet Answers:

1. Being appropriately dressed gives a sense of identity and enhances the client's self-image.

2. Provide clients who have difficulty making decisions with a choice between two different outfits. Assist the client to select appropriate clothing.

3. a. Acute care - family does the client's personal laundry
   b. Long-term care - sometimes families take responsibility for the client's personal laundry. If the family does the laundry, a notice will be posted in the client's room that the family is responsible for the client's personal laundry. The family must provide a container in which to place soiled articles until they can be picked up. If the family does not do the client's personal laundry, it is placed in the facility's laundry or where designated by the facility.
   c. Home health care - family will indicate where soiled articles are to be placed

4. a. Client with a weak or paralyzed side - the weak or nonfunctioning side is dressed first and undressed last
   b. Client who is very weak - put on underclothes, stocking/socks and slacks while the client is lying down
   c. Client who needs total assistance - can be completely dressed in bed before they are transferred to a chair
   d. Client with stockings that support circulation - apply stockings before the client sits up or gets out of bed

Lesson 4: Bathing

Objectives:

1. Identify the purposes of bathing.
2. Identify and differentiate types of baths.
3. Discuss general considerations for bathing.
4. Describe safety measures needed during bathing.
5. Discuss adaptations for giving or assisting with a bath in the home.
6. Give a complete bed bath.
7. Give a tub bath.
8. Give a whirlpool tub bath.
9. Give a shower bath.

Teaching Strategies:

1. The anatomy and physiology of the skin may need to be reviewed before beginning the lesson.

2. Arrange for the class to visit a long-term care facility where bathing is not likely for many clients and students can see a whirlpool tub bath demonstrated. If the long-term care facility allows use of the bathing facilities, students can practice positioning each other in the whirlpool chair and raising and lowering it into the tub.

3. Check with the local health care facilities to see if any other special kinds of bathing are done in the area. If so, these may need to be explained and demonstrated.

4. Demonstrate the complete and partial bed bath to the students using a mannikin. To demonstrate the other types of bathing, arrange with a local health care facility to use the bathing facilities at a time that does not affect client care.

5. Many instructors have the students bathe each other. Students can wear bathing suits to practice these procedures. This serves two purposes: 1) it allows students to practice the procedure on a "real" person, and 2) it gives the students some insight into the feelings of clients who must have a complete or partial bed bath.

Audiovisual Supplement (available from MVRC):

Techniques in Bathing. Videocassette. The Nursing Assistant Series, CA Medcom, Inc., 1990. 37 min.

Activity Sheet Answers:

1. Answers should include six of the following:
   - Promotes cleanliness and comfort
   - Stimulates circulation
   - Stimulates skin
   - Assists in keeping the muscles functional
   - Cools the body
   - Allows nurse assistant to observe the condition of the skin
   - Allows for communication with the client
   - Relaxs and refreshes the client

2. a. Complete bed bath - involves washing the total body while the client is in bed.
   b. Partial bed bath - involves washing only the face, hands, axillae and perineal area while the client is in bed.
   c. Tub bath - given in a regular bathtub to clients who are mobile.
   d. Whirlpool tub bath - usually given in long-term care and requires a special whirlpool tub.
   e. Shower bath - given in a shower with the client either standing or sitting in a chair.

3. a. The room should be warm and without drafts.
   b. Expose the client as little as possible before, during or after bathing.

4. A mitten can be made from the washcloth.

5. a. Tubes should not be pulled on, kinked, or placed under a client's extremity or body.
   b. Drainage tubes should not be raised above the drainage sites.
   c. IV containers should be kept higher than infusion site.
   d. Oxygen tubing should only be removed long enough to bathe the clients' faces.

6. If signs of distress are present, stop the bath and notify the supervisor.

7. Answers should include four of the following:
   - The temperature of the water should be between 90°F and 105°F.
   - The bathroom door should NEVER be locked.

- If the client can be left alone, they should be checked on frequently.
- Assist with all transfers in and out of the tub or shower.
- Non-skid mat or strips should be used in the bottom of the tub or shower.
- A call device should be available or an emergency signal established to get assistance.
- Practice good body mechanics.

8. Answers should include three of the following:
   - Keep the hand-held shower nozzle up off the floor to prevent falls.
   - The shower chair wheels should be locked.
   - The shower chair is positioned facing the door.
   - The nurse assistant should stand facing the client for better control.
   - A strudy, stable, waterproof chair can be used in a shower at home.
   - Soap should NOT be left lying on the floor.

9. Step 1: Call for help.
   Step 2: Support the client with his or her head out of the water.
   Step 3: Drain the water out of the tub.
   Step 4: Once the water is drained, lower the client's head as much as possible.
   Step 5: Cover the client with a bath blanket.
   Step 6: Wait for the supervisor to assess the client's condition.
   Step 7: Gain assistance to lift the client from the bathtub and return the client to bed.

10. Answers should include four of the following:
    - Fill the tub with just enough water to cleanse the client.
    - Do not allow the client to stay in the tub for too long.
    - Bath oil should not be used.
    - Soap should not be allowed to stay in the water.
    - Partially or completely drain the tub before the client attempts to get out.

11. Step 1: Call for help.
    Step 2: Support the client.
    Step 3: Turn off the water.
    Step 4: If the client is standing, have him or her sit.
    Step 5: If no chair is available, slide the client down the wall of the shower to sit on the floor.
    Step 6: If no chair is available, slide the client down the wall of the shower to sit on the floor.
    Step 7: Cover the client with a bath blanket or towel.
    Step 8: Wait for the supervisor to assess the client's condition.
    Step 9: Gain assistance lift the client and return the client to bed.

12. Answers should include five of the following:
    - Use light cotton blankets or large towels for the bath blanket.
    - Take care that water is kept off the bed linens.
    - Use bathing materials supplied by the family.
    - Nightstands or other small household tables can be used for the bath basin and other supplies. These should be covered with a waterproof or thick absorbent cover.
    - If water has to be carried a distance, it may need to be changed more frequently.

- The client should have enough mobility to step up over the edge of the shower if that type of bathing is used.
- A tub bath should be given only if the client has the ability to raise and lower himself or herself from the tub.

Lesson 5: Shaving

Objectives:

1. Discuss general considerations for shaving a client.
2. Shave the client with a safety razor.
3. Shave the client with an electric razor.

Teaching Strategies:

1. Bring in a disposable, safety razor and some shaving cream to let the students see and feel the razor and shaving cream.

2. Bring in an electric razor and let the students practice turning it off and on and removing and cleaning the heads.

3. If male students are willing, have female students practice shaving them. This should not be mandated. The same applies to males shaving female students' legs for practice.

4. If students are on the clinical unit, they should be assigned to male clients who need shaving. They could be assigned to do several shaves that day using both an electric razor and a safety razor.

Audiovisual Supplement (available from MVRC):

Techniques in Personal Care. Videocassette. The Nursing Assistant Series, CA Medcom, Inc., 1990. 22 min. *(A part of the video is about shaving.)*

Activity Sheet Answers:

1. Shaving is done in a client's room or a bathroom, NEVER in a public area.

2. A disposable safety razor can be used.

3. Client who are receiving oxygen may only use an electric razor if the oxygen can be removed during the procedure.

4. An electric razor should be used to prevent nicking the skin and causing bleeding.

5. a. Apply lather or shaving cream.
   b. Apply warm water.

6. The nurse assistant should put on gloves (if not already being worn) and then apply pressure to the nick using a clean cloth. The supervisor should be notified of the occurrence.

Lesson 6: Hair Care

Objectives:

1. Identify the purposes of hair care.
2. Discuss general considerations in giving hair care.
3. Identify safety precautions that should be taken while giving hair care.
4. Identify special hair care needs.
5. Comb/brush hair.
6. Give a shampoo during a tub/shower bath.
7. Give a bed shampoo.

Teaching Strategies:

1. Show the class pictures of infestations of lice or other insects in the hair. Most medical-surgical nursing books or fundamentals of nursing books have illustrations of infestations. The school nurse may also have pictures. Invite the school nurse to discuss signs of infestations and how to treat them. The county health department may also have educational resources regarding infestations.

2. If the school has a cosmetology program, ask the instructor to discuss general tips for hair care and how to arrange hair attractively for different types of face shapes.

3. Bring in examples of dry shampoos that are available at the local drug store. Have students use the products to shampoo their own hair to see and feel how the shampoos work.

4. The students can use each other as clients to practice positioning a client at a sink for a shampoo and using a shampoo trough for giving a wet shampoo to a client in bed.

Audiovisual Supplements (available from MVRC):

1. *Techniques in Personal Care.* Videocassette. The Nursing Assistant Series, CA Medcom, Inc., 1990. 22 min. *(A part of the video is about assisting with hair care.)*
2. *Techniques in Bathing.* Videocassette. The Nursing Assistant Series, CA Medcom, Inc., 1990. 37 min. *(A part of the video is about shampoos.)*

Activity Sheet Answers:

1. Answers should include five of the following:
   - To improve the client's appearance
   - To cleanse the hair and scalp of dirt particles and dead cells to keep it healthy
   - To keep the hair untangled

- To stimulate circulation to the scalp
- To observe scalp
- To provide mild exercise for the hands and arms

2. In the morning as part of the early morning personal care routine, then at various times again during the day to maintain the client's appearance.

3. Hair should be washed as often as needed to promote cleanliness.

4. Answers should include three of the following:
   - In the shower with the client either sitting on a shower chair or standing
   - In a home sink, the client can bend over or sit with his or her head tilted back over the sink
   - From a gurney backed up to a sink with a spray nozzle
   - In bed with a dry shampoo or with a shampoo trough
   - In a whirlpool tub

5. A dry shampoo is a commercial preparation, usually foam based, that absorbs the excess oil and accumulated dirt in the hair.

6. Tangles should be separated from the rest of the hair into sections that can be held firmly near the scalp. Comb or brush the tangles out working from the ends to the scalp.

7. Answers should include three of the following:
   - Label each client's personal hair care items.
   - Use the client's own comb and brush.
   - Do not share hair rollers or curlers between clients.
   - Place a towel around the client's shoulders while combing or brushing to collect hair and debris that is shed during the procedure.
   - Clean combs and brushes after each use.

8. Answers should include four of the following:
   - Keep one finger in the stream of water from a nozzle to monitor water temperature and pressure.
   - Maximum water temperature for shampooing should be 105°F.
   - Keep hair dryer temperature on low and check frequently.
   - Keep a hand under the air stream of the hair dryer so temperature can be monitored.

   - Do not use hair dryers near a tub or over a sink full of water.

9. Answers should include three of the following:
   - Wash hair once a week or once every two weeks.
   - Lightly oil hair and scalp once a week if the hair is very dry.
   - Using a wide tooth comb is best.
   - If the hair has been professionally straightened, roll hair on sponge curlers wrapped in paper or tissue each night and lightly oil the hair and scalp weekly.
   - A special professional shampoo or a softening shampoo, such as baby shampoo, is best for washing the hair.
   - A conditioning detangler should be applied as the hair tangles easily.

- If the hair is allowed to dry hanging loose, it must be constantly combed to prevent tangles.
- A wet-hair setting lotion can be applied before rolling the hair on rollers if the client wishes the hair curled.
- A hair dryer can be used to speed up drying if the hair is braided.

Lesson 7: Oral Hygiene

Objectives:

1. Identify the purposes of oral hygiene.
2. Discuss the general considerations in giving oral hygiene.
3. Describe the general considerations in performing denture care.
4. Assist with oral hygiene for a conscious client.
5. Provide flossing of teeth.
6. Administer oral hygiene to helpless or unconscious clients.
7. Provide denture care.

Teaching Strategies:

1. Check with a local dentist to see if he or she has denture models for teaching brushing. A local long-term care facility may also have some unclaimed dentures that can be used for practice.

2. Show the students pictures of tooth decay. Health assessment books may have pictures in them. A local dentist may have color pictures of different types of tooth decay and gum disease.

3. Many students have never seen a denture cleansing tablet other than on a television commercial. Bring a tablet in so that students can see how it works.

4. Students can bring in toothbrushes and toothpaste for practice sessions. A local dentist's office often has toothbrushes to give away and may be able to furnish toothpaste as well. Dental floss may be purchased at the store for classroom use, or a dentist's office may be able to provide samples.

5. Check with local health care facilities for any special devices that are used in oral care procedures at the facilities. See if they will be willing to donate enough devices for each student or at least one to use in a demonstration.

6. If students are at the clinical site, they could be responsible for performing oral care on clients.

Audiovisual Supplement (available from MVRC):

Oral Care Techniques. Videocassette. The Nursing Assistant Series, CA Medcom, Inc., 1990. 12 min.

Activity Sheet Answers:

1. Answers should include five of the following:
   - To remove food particles and plaque from the teeth and mouth
   - To keep the teeth and gums healthy
   - To stimulate circulation to the gums
   - To remove accumulated food particles that could lead to an infection
   - To reduce halitosis
   - To eliminate bad tastes in the mouth, making food taste better and enhancing the appetite
   - To observe the mouth and gums
   - To provide mild exercise for the hands and arms

2. Answers should include three of the following:
   - Tooth decay (blackened teeth)
   - Loose or broken teeth
   - Red or swollen gums
   - Sores or white patches in the mouth or on the tongue
   - Changes in eating habits (the client may eat only soft foods that require little chewing if mouth pain is present)
   - Poorly fitting dentures

3. Answers should include two of the following:
   - Some clients will want to brush their teeth before breakfast to get rid of "morning mouth" before they eat.
   - Other clients will wish to brush their teeth after meals and at bedtime (this is the general standard to follow for giving oral hygiene).
   - Oral hygiene should be given every two hours to unconscious clients or clients on oxygen because they breath through their mouths, causing secretions to stick on mouth surfaces.
   - Frequent oral hygiene should be given to clients who experience high temperatures or dehydration causing the mouth to be very dry.
   - Frequent oral hygiene should be given to clients who have been vomiting due to the bad taste, or clients who are dying due to the accumulation of toxins in the mouth.

4. By using both horizontal and vertical strokes to cover all surfaces of the teeth.

5. Flossing is the use of a specially waxed or unwaxed string to remove particles of food between the teeth and to stimulate the gums.

6. Answers should include five of the following:
   - Handle dentures carefully to prevent damage as they are very expensive.
   - Holding dentures with a washcloth or paper towel prevents them from slipping out of your hands when they are wet and slick.
   - Placing a washcloth or paper towel in the sink when cleaning dentures provides a cushion if they should fall.
   - Dentures can be cleaned over a partially filled sink to provide a cushion if they should fall.

- Dentures should be kept in clean, cool water when they are not in the mouth to keep them from warping.
- Do not use hot water to clean or store dentures; the heat may loosen the teeth.
- Dentures should be stored in a denture cup labeled with the client's name.
- Dentures can be soaked overnight in a cup with a cleansing tablet.
- Dentures should be brushed daily.

Lesson 8: Nail Care

Objectives:

1. Identify the purposes of nail care.
2. Discuss general considerations in giving nail care.
3. Give fingernail care.
4. Give toenail care.

Teaching Strategies:

1. Find pictures of changes in the nails to show to students. Assessment books usually have some pictures of abnormalities and disease processes. A local dermatologist or podiatrist may also have color pictures of abnormalities.

2. Bring in nail care utensils, such as an orange stick, nail clippers, an emery board and cuticle scissors, so the students can examine the equipment.

3. If the school has a cosmetology program, an instructor could be invited to talk about general nail care. Also, the cosmetology students might like to practice nail care on the health occupations students. This will help the students understand what it is like to have someone else do nail care for them. When the cosmetology students are through, discuss the students' feelings about having nail care done, what they liked about it, and what they did not like.

4. Have students provide nail care for one another. They may also bring in their favorite nail polish for a partner to put on.

5. Local long-term care facilities always needs people to do nail care. Special arrangements could be made to allow the students to do nail care on as many residents as possible.

Audiovisual Supplement (available from MVRC):

Techniques in Personal Care. Videocassette. The Nursing Assistant Series, CA Medcom, Inc., 1990. 22 min. *(A part of the video is about nail care.)*

Activity Sheet Answers:

1. Answers should include four of the following:
   - To prevent damage to the skin
   - To provide a pleasant appearance
   - To remove the safety hazard of ragged and long nails; preventing cuts and scratches
   - To prevent infections from bacteria growing in dirt accumulated under nails
   - To prevent infections from nail bacteria deposited in cuts or in the mouth
   - To observe the surrounding skin and condition of the nails
   - To observe nail bed color that may show the client's respiratory status

2. Answers should include six of the following:
   - Nails should be checked regularly for cleanliness.
   - Accumulated material should be removed from under the nails.
   - An orange stick is best for cleaning under nails.
   - Nails should be trimmed and shaped as often as necessary to keep them short and smooth.
   - Nails should be checked for hangnails and ingrown nails and the supervisor notified if either are present.
   - Soaking nails in warm water makes them softer and easier to trim.
   - Toenails are thicker than fingernails and may require a longer soaking time.
   - Nails should be trimmed straight across and not too close to the flesh.
   - Clippers are easier and safer to use than scissors.
   - An emery board can be used to smooth and shape the nails.
   - A licensed nurse or podiatrist is responsible for trimming the nails of clients with diabetes as these clients usually have poor circulation and heal slowly if injured.

3. An orange stick is a short, round stick with a pointed end and a beveled end used to clean out the material accumulated under nails.

4. A licensed nurse or podiatrist is responsible for trimming nails of clients with diabetes because they usually have poor circulation and heal slowly if injured.

Lesson 9: Perineal Care

Objectives:

1. Identify the purposes of perineal care.
2. Discuss general considerations in giving perineal care.
3. Give perineal care to a female client.
4. Give perineal care to a male client.
5. Give perineal care to a client with a catheter.

Teaching Strategies:

1. Students may experience a great deal of embarrassment in a discussion of perineal care. Anatomically correct models should be used when the students practice the techniques,

which will give them with a greater degree of comfort when actually working with patients.

2. Check with local health care facilities for their policies regarding perineal care. Incorporate this information into the lesson.
3. Obtain a peribottle or other perineal care products for demonstration.
4. Students usually are very reluctant and/or hesitant to do these procedures at the clinical site. It may be wise for the instructor to be present or for a supportive licensed person of a health care facility to be with students as they practice this skill on clients.

Audiovisual Supplement (available from MVRC):

Techniques in Bathing. Videocassette. The Nursing Assistant Series, CA Medcom, Inc., 1990. 37 min.

Activity Sheet Answers:

1. Perineal care is the washing of the genital and rectal area of the body.
2. Answers should include three of the following:
    - To cleanse the area of secretions and accumulated waste products
    - To prevent odors and infections
    - To prevent skin breakdown
    - To promote the general comfort of the client
    - To promote healing
3. Answers should include two of the following:
    - As a part of daily cleaning
    - When odor is present
    - When a client is incontinence
    - When a client has an indwelling catheter
    - After childbirth
    - After surgery
4. After each voiding or bowel movement
5. At least once each shift and after each bowel movement
6. Female - from front to back
   Male - from tip of penis, down shaft, to scrotum and to rectum
7. The client should be in a supine position, if possible. Otherwise, perineal care may be performed with the client in a side-lying position, or it may be incorporated as part of the bathing procedure.
8. In an uncircumcised male, the foreskin must be pulled back, the head of the penis washed, and the foreskin replaced.

Lesson 10: Backrub and Skin Care

Objectives:

1. Identify purposes of the backrub and skin care.
2. Describe the observations to make while giving a backrub and skin care.
3. Discuss the general considerations in giving a backrub and skin care.
4. Give a backrub.

Teaching Strategies:

1. Obtain pictures of skin conditions for the students to observe. Especially important are the pictures of the stages of skin breakdown. Color pictures can usually be obtained from representatives from drug companies that sell skin care products.

2. Have the students practice pressing on their skin to see it blanch.

Audiovisual Supplements:

Check with representatives from drug companies for possible videos or slides regarding skin care and the staging of pressure ulcers.

Activity Sheet Answers:

1. Answers should include three of the following:
   - To stimulate circulation
   - To assist in preventing skin breakdown
   - To relax muscles and cause general relaxation
   - To encourage communication
   - To observe the condition of the skin

2. a. Blanching is when the skin whitens when pressed, then immediately returns to its original color.
   b. Mottled skin is irregular bluish-purple patches that feel cool to the touch.

3. Answers should include six of the following.
   - Redness or irritation
   - Blanching
   - Mottling
   - Breaks in the skin, such as cuts, abrasions, burns or sores
   - Excessive dryness
   - Rashes
   - Bruises
   - Swelling
   - Lumps
   - Growths

4. Answers should include three of the following:
   - As part of the bathing procedure
   - Following the use of a bedpan
   - Before changing the position of the helpless client
   - At bedtime to clam a client
   - When a client needs comfort or relaxation

5. Place the bottle in a pan of warm water or squeeze the needed amount into the hands and warm it with body heat.

6. a. Long, smooth strokes - relax and stimulate the skin
   b. Circular strokes - loosen tight muscles

Lesson 11: Bedmaking

Objectives:

1. Differentiate between the types of bedmaking.
2. Discuss key points in making a bed.
3. Make an occupied bed.
4. Make an unoccupied bed.

Teaching Strategies:

1. After presenting the lesson and demonstrating the correct techniques, allow students to practice bedmaking procedures with and without a partner.

2. If the classroom laboratory is limited in the types of beds available, arrangements can be made with a local health care facility for students to come in and work with different types of beds (electric, etc.) in an empty room or in a teaching lab.

3. Once the students have practiced the procedure in the lab, if they are at the clinical site, they could be assigned to make the beds.

Audiovisual Supplement (available from MVRC):

Techniques in Bedmaking. Videocassette. The Nursing Assistant Series, CA Medcom, Inc., 1990. 15 min.

Activity Sheet Answers:

1. a. Open bed - one in which the top linens are fanfolded to the bottom of the bed.
   b. Surgical bed - prepared for a client returning from surgery. It has extra protective linen on it and is left in the high position to accommodate the transfer of a client from a gurney.
   c. Closed bed - one in which the top linens are spread up to cover the bottom linens to protect them from the accumulation of dust in the environment

2. a. Stack linen in order of use.
   b. Make one side of the bed and then go to the other side to finish it.

3. Answers should include two of the following:
   - Linen should not be shaken.
   - Soiled areas should be rolled to the center and folded into the rest of the linens.
   - Discard gloves used on soiled linen, wash hands and put on clean gloves BEFORE working with clean linen.
   - Soiled linens should be kept away from the hands, face, and uniform.
   - Carry dirty linens in a bag or rolled and held away from the body.
   - Dirty linens should NEVER be thrown on the floor.

4. A toe pleat is an extra fold in both the top sheet and the bedspread that prevents the restriction of circulation in the feet and foot drop.

5. Answers should include two of the following:
   - The linen available in the home must be used.
   - Accommodate the way the client likes the bed to be made unless it creates a safety hazard.
   - Do not use torn linen as body parts can ecome caught in a tear and circulation can be restricted.
   - Cover any plastic bed protectors with an extra sheet so the plastic does not come in direct contact with a client's skin.
   - To minimize the amount of laundry, an unsoiled top sheet can be used as the bottom sheetwhen bed linens are changed.

Lesson 12: The Client's Environment

Objectives:

1. Identify elements of the client's environment.
2. Discuss general considerations in maintaining the client's environment.
3. Maintain the client's environment.

Teaching Strategies:

1. Gather the equipment that is usually in a client's environment in a long-term care facility: bed, chair, call device, water pitcher, glass, tissue, bedside table and overbed table. Have the students arrange the environment in such a way that a client can reach everything.

2. Discuss variations in client environments that the students have found in their visits to health care facilities.

Activity Sheet Answers:

1. Answers should include six of the following:
   - Hospital bed
   - Bedside table
   - Overbed table
   - Call device
   - Light
   - Chair
   - Closet or storage area
   - Television
   - Personal furniture
   - Personal items; pictures, plants, etc.

2. Answers should include four of the following:
   - Clean furniture surfaces for infection control.
   - Wipe up spills immediately for safety.
   - Neatly store all equipment and client's personal items when not in use.
   - Position furniture for the client's use and for safe movement of everyone who enters the room.
   - Position call device within easy reach for clients.
   - Promptly answere all call devices.
   - Supply fresh water, ice, drinking cups, tissues and straws to clients.
   - Place fresh towels and washcloths in clients' bathrooms as needed.
   - Place cards so clients can enjoy them without hindering care-giving.
   - Water and remove dead flowers for clients.
   - Maintain temperature between 70°-75°F; contact maintenance or environmental services if necessary.
   - Use curtains or screens to shield clients from drafts.
   - Open windows for air circulation if applicable.
   - Maintain sufficient lighting to perform tasks.
   - Protect clients and self from coming into contact with light bulbs that have been on.
   - Keep noise level at a minimum.

3. Answers should include two of the following:
   - Maintain client's environment as he or she wishes.
   - Seek instructions as to the client's preferences if responsible for light housekeeping.
   - Do Not rearrange or move any personal furniture or items without the client's permission.
   - Devise a call system for the client when you are out of the room
   - Adjust temperature, air circulation and lighting according to the client's desires.

4. 70-75°F

5. It may feel slightly warm, even hot to staff, but may be comfortable to ill clients who are more sensitive to cooler air and who must remain in the room while others come and go.

6. Answers should include two of the following:
   - Speak quietly.
   - Handle equipment carefully.
   - Keep the television or radio volume turned down.
   - Keep equipment maintained.

Answers to Written Unit Evaluation:

1. b
2. a
3. a
4. c
5. d
6. c
7. a
8. b
9. d
10. c
11. c
12. a
13. d
14. c
15. b
16. b
17. d
18. a
19. c
20. a
21. c
22. b
23. b
24. b
25. a
26. a
27. c
28. a
29. a
30. a
31. d
32. d
33. d
34. b
35. d
36. c
37. a
38. b
39. c
40. d
41. b
42. c
43. c
44. d
45. c
46. d
47. a
48. c
49. c
50. c
51. b
52. d
53. d
54. c
55. b
56. c
57. d
58. d
59. m
60. a
61. b
62. j
63. f
64. c
65. l
66. o
67. n
68. h
69. q
70. e
71. g
72. b
73. a
74. g
75. d
76. e

Unit VI

Restorative Nursing

Overview of the Unit

This unit discusses how the nurse assistant aids the mobilization of clients. The unit contains four lessons, moving and positioning a client, transferring a client, ambulation, and range of motion exercises.

Lesson 1: Moving and Positioning the Client

Objectives:

1. Discuss general considerations in moving and positioning clients.
2. Identify aids to moving and positioning clients.
3. Assist or raise a client's head and shoulders.
4. Move a helpless client to the head of the bed.
5. Move or assist a client to the head of the bed.
6. Move a client to one side of the bed.
7. Turn a client to his or her side.
8. Turn a client to a prone position.

Teaching Strategies:

1. Review body mechanics and the seven basic positions from the *Health Care Assistant Core* curriculum.

2. Show the students how to make and use a lift/draw sheet.

3. If bolsters, wedges, sandbags and footboards are not available in the clinical laboratory, obtain them from a local health care facility or physical therapy department. If equipment cannot be borrowed, ask if students may view and practice with the items at the health care facility.

4. Ask a physical therapist to speak to the class about positioning.

5. Demonstrate the procedures and allow the students time to practice them with a student partner in the laboratory.

Audiovisual Supplement (available from MVRC):

1. *Nursing Assistant Techniques: Positioning Techniques.* Videocassette. CA Medcom, Inc., 1990. 14 min.
2. *Nursing Assistant Techniques: Lifting and Moving Techniques.* Videocassette. CA Medcom, Inc., 1990. 14 min.

Activity Sheet Answers:

1. Exercise will help keep body systems functioning; even a small amount of exercise is better than no exercise at all.

2. a. If the client is very heavy
   b. When the client has tubes

3. The heaviest part of the client's body

4. Block it or position it against a solid surface to prevent it from moving

5. Alignment is positioning body parts so that the body can function at its best and be comfortable.

6. A lift/turning sheet is a folded, standard sheet, placed under the trunk of a client's body to assist in moving and positioning the client.

7. A trapeze is a triangular grab bar that hangs above the client's chest and within the client's reach.

8. a. Bed pillows - used to hold or support a body part in position or wedge against a body part to keep it in position
   b. Rolled towels and blankets - used to immobilize a body part or hold it in position
   c. Bolsters or wedges - used to elevate the trunk of the body or body part or to prop a client on his or her side
   d. Sandbags - used to immobilize a body part
   e. Footboard - used as a solid, flat surface for a client's feet to rest against to prevent footdrop

Lesson 2: Transferring the Client

Objectives:

1. Compare the types of client transfers.
2. Describe safety measures to observe when transferring clients.
3. Identify pieces of equipment used for transfer activities.
4. Discuss transferring clients at home.
5. Describe positioning and alignment of a client in a chair.
6. Transfer a client from bed to chair.
7. Transfer a client from chair to bed.
8. Transfer a client using the mechanical lift.
9. Transfer a client from bed to gurney.
10. Transfer a client using a three-person carry transfer.
11. Transfer a client using a two-person sitting transfer.

Teaching Strategies:

1. Ask a physical therapist to speak to the class about transfers.

2. Show transfer equipment to the students. Demonstrate the procedures and allow the students to practice the procedures with a partner. Have students role-play being and assisting clients with various disabilities, i.e., weakness, hemiparesis.

3. After properly positioning a student in a chair, time the student to see how long he or she can stay in that one position without needing to move. Discuss how long students can sit in one position compared with time some clients must sit in one position. Discuss the students' feelings about not being able to move and being dependent on another person to help them to change positions.

4. If a mechanical lift is not available in the clinical laboratory, check with a local health care facility tc see if the students could come to the facility and practice with the device. The students understand much better how the client feels if they have had the experience of being lifted out of bed with the device.

5. Assign students to work with a restorative aide in the long-term care facility to do transfers and chair positioning.

Audiovisual Supplement (available from MVRC):

Nursing Assistant Techniques: Transfer Techniques. Videocassette. CA Medcom, Inc., 1990. 21 min.

Activity Sheet Answers:

1. a. Independent - client can do without any direct assistance from another person
   b. Dependent - requires the assistance of at least one other person
   c. Active-assisted - where a client can help partially
   d. Passive-assisted - when a client cannot help in any way

2. Answer should include five of the following:
   - Determine whether the transfer can be accomplished by one person or if help is needed.
   - Check the equipment for safety before beginning the transfer.
   - Gain the client's understanding and assistance.
   - Use good body mechanics.
   - Make the transfer surfaces nearly the same height, if possible.
   - Position the chair on the functional side of a client who has a weak or nonfunctional side.
   - When moving a weak client, control the shoulders and hips of the client.
   - Lock equipment during the transfer.
   - Place non-locking chairs or beds against a solid surface, such as a wall so it does not move.
   - Keep the wheelchair footrests up and out of the way.

- Move the client from a lying to a sitting position slowly so his or her blood pressure can adjust.

3. a. Gait belt - a special transfer belt that the nurse assistant uses as a handle to lift, maneuver, and hold onto the client
   b. Sliding board - a smooth wooden or vinyl board that allows the client to slide from one surface to another
   c. Sling - a cloth device used to cradle an arm or hand so the client can maintain balance and keep the arm or hand from being injured
   d. Mechanical lift - a mechanical device that can be used to move a client when the client is too heavy to lift

4. Answers should include one of the following:
   - Use transfer methods for one person or obtain help from other care givers who know transfer techniques.
   - Standard hospital equipment may not be available; check stability of beds and chairs and position to prevent falls
   - Chairs should be selected to provide good support for the back, have arms and to be at a height that it is not difficult for the client to stand
   - Carry the gait belt to the home or use a solid leather belt that the client may have

5. Answers will vary but should include the following:
   - Support the client's forearms with pillows.
   - The client's back should be straight against the back of the chair.
   - Place a small pillow in the lumbar curvature of the spine.
   - The client's hips and buttocks should be against the back of the chair.
   - The backs of the knees should be free of pressure from the edge of the chair.
   - Position feet flat on the footrests of a wheelchair or on the floor.
   - The client's weight is supported by the thighs and buttocks.

6. Answers will vary but should include the following:
   - Apply a gait belt to the client's waist.
   - One assistant stands on one side of the client, another on the opposite side.
   - Each assistant grasps the belt in back and places one hand under the client's thigh in front.
   - Together the assistants lift and move the client back in the chair.

Lesson 3: Ambulation

Objectives:

1. List the purposes of ambulation.
2. Describe the ambulation aids that can be used to assist a client.
3. Discuss general considerations when assisting a client with ambulation.
4. Identify safety measures that should be taken when assisting a client with ambulation.
5. Ambulate a client with a gait belt.
6. Ambulate a client who is using a walker.

7. Ambulate a client who is using a cane.
8. Ambulate a client who is using crutches.

Teaching Strategies:

1. Obtain equipment to demonstrate usage during the lesson. Allow time for students to practice using the equipment.

2. Ask a physical therapist to speak to the class about ambulation.

3. Ask students if they have had a broken leg or other injury that prevented ambulation. Find out what types of devices they used to assist them with ambulation. Have students discuss their feelings about not being able to ambulate. Ask students how using the devices to assist with ambulation limited them in being able to do their activities of daily living.

4. If equipment, such as canes, walkers, and crutches, is not available in the laboratory, find out if a local health care facility or physical therapy department will lend the equipment. If a loan is not available, ask if students may visit the facility to practice with the equipment. A local physical therapy department may also have audiovisual supplements for the lesson.

Activity Sheet Answers:

1. Answers should include three of the following:
   - Promotes muscle tone
   - Improves strength and endurance
   - Assists with preserving the bone structure
   - Promotes independence and provides a sense of accomplishment
   - Stimulates the bowel to contract
   - Promotes circulation to the legs

2. a. Walker - come in various styles and are used when the client requires some support when walking due to problems with balance or due to weakness
   b. Cane - also come in various styles depending on the client's need and are used when the client can bear full weight; used to maintain balance
   c. Quad cane - a cane with four legs that provides a wider base of support giving more stability
   d. Crutches - used by those who have sufficient upper body strength to support their body weight
   e. Brace - used for the client who needs specific support for weakened muscles or joints or can be used for immobilization of an injured part
   f. Transfer or gait belt - assistive device used to guide and support the client during ambulation and other activities

3. Answers should include six of the following:
   - Decreased muscle strength
   - Changes in the center of gravity
   - Inability to maintain upright body posture

- Decreased sensory perception
- Impaired balance
- Confusion
- Drugs that cause the client to be weak or lose their balance
- Prone to falls
- Easily distracted
- Previous falls

4. Answers should include three of the following:
   - Steadiness of gait
   - Balance
   - Endurance
   - Ability in ambulation
   - Signs of fatigue, such as difficulty breathing, sweating, dizziness, and rapid heart beat

5. Answers should include ten of the following:
   - Use good body mechanics.
   - Allow the client to sit on the side of the bed before ambulating.
   - Choose an area for ambulation that is free from clutter.
   - Make sure ambulation area floors are not slippery.
   - If possible, the ambulation area should have handrails along the walls.
   - Plan for the client to sit by having a chair nearby or ready at the end of the ambulation distance.
   - Client should wear nonskid shoes or slippers.
   - Know the proper techniques for using assistive devices.
   - Check rubber tips on canes, crutches and walkers frequently.
   - Assistive devices should be checked that screws and bolts are securely in place before the client uses them.
   - Let the client rest when signs of fatigue are present.
   - If a client is falling and cannot be stabilized with a gait belt, allow the client to slide down along the assistant's hip and thigh to the floor.

Lesson 4: Range of Motion Exercises

Objectives:

1. Identify the purposes of range of motion exercises.
2. Compare the types of ranges of motion exercises.
3. Discuss the general considerations in performing ranges of motion exercises.
4. Perform range of motion exercises.
5. Assist with active range of motion exercises.

Teaching Strategies:

1. Review the different types of joints in an anatomy, physiology, or a fundamentals of nursing textbook. Choose a book that illustrates the degrees of motion for each joint. Ask an artist or graphic artist to draw pictures from which you can make transparencies.

2. Use your body or a student's to model to the class the types of motion each joint produces.

3. Ask a physical therapist to demonstrate the range of motion exercises to the class.

4. Allow time for students to practice the range of motion exercises on each other.

5. Assign students who are on the clinical unit to do range of motion exercises on a variety of clients.

Audiovisual Supplement (available from MVRC):

Nursing Assistant Techniques: Exercise Techniques. Videocassette. CA Medcom, Inc., 1990. 16 min. (a part of the video is about range of motion exercises).

Activity Sheet Answers:

1. Answers should include three of the following:
   - Maintains healthy muscles
   - Prevents muscles from losing strength and shrinking
   - Prevents the joints from becoming stiff
   - Prevents the loss of minerals from the bones
   - Promotes circulation

2. a. Passive range of motion - the nurse assistant does these exercises on a client who does not or cannot help in any way
   b. Active-assistive range of motion - means the client moves independently as much as possible with the nurse assistant doing those joints that the client cannot move
   c. Active range of motion - the client does these exercises without assistance
   d. Resistive range of motion - exercises done by the client against pressure provided by the nurse assistant

3. During or after a bath the muscles may be more flexible due to the relaxing effect of the warm water.

4. The number of repetitions for the joint may be ordered by a physician or a therapist. If the number of repetitions is not specified, exercises should be done three to five times.

5. The body part to be exercised should be held above and below the joint.

6. Observe the client to make sure the exercises are being done correctly and to give instruction and encouragement.

Answers to Written Unit Evaluation

1. c
2. b
3. d
4. a
5. d
6. c
7. b
8. b
9. a
10. d
11. b
12. c
13. a
14. d
15. c
16. a
17. b
18. d
19. c
20. b
21. b
22. c
23. d
24. i
25. c
26. k
27. d
28. a
29. h
30. f
31. b
32. g
33. c
34. a
35. d
36. b

Unit VII

Nutrition

Overview of the Unit

This unit discusses the nutritional aspects of the care of clients. The preparation of the client for meals in the areas of serving, feeding and monitoring are discussed. Lessons on intake and output, and weight and height are also included. These measures are used to determine the nutritional status of clients.

Lesson 1: Preparing the Client for Meals: Serving, Feeding and Monitoring

Objectives:

1. Discuss general considerations in preparing clients for mealtime.
2. Prepare a client for a meal.
3. Explain how to prepare and serve food trays.
4. Distribute trays, assisting with tray set-up.
5. Identify key points in feeding a client.
6. Feed a helpless client.
7. Describe after-meal care.
8. Discuss meal preparation and serving in a client's home.
9. Identify key points in meeting nutritional needs of clients with special problems.
10. Modify feeding technique as appropriate for a client's condition.
11. Discuss the nurse assistant's role in providing alternate methods of nutrition.

Teaching Strategies:

1. Have the dietician or food service supervisor from a local health care facility speak to the class about serving meals.

2. Occupational therapy or speech therapy, whichever department handles swallowing difficulties in clients, could speak to the class about modifications to feeding.

3. Discuss what happens at the students' mealtime. Determine positive and negative experiences. Talk about why the students like to gather at the local fast food place to eat.

4. Discuss ways in which the students' appetites are enhanced or diminished.

5. Demonstrate the procedures from the lesson, then allow the students time to practice the skills. The feeding procedure could be done in conjunction with a potluck dinner or common but hard-to-feed items, such as applesauce, Jell-O, or pudding, could be provided by the instructor.

6. Purchase a can of Ensure and allow the students to taste a small amount.

7. When the students are at the clinical site, a pureed tray can be obtained for a taste test. After the students have tasted the different items, the food can be mixed all together to let the students see how unappetizing it is when nurse assistants do this. Discuss the students' feelings about the food: why it was unappetizing, why would they not want to eat it.

8. The students can make a thickened liquid with a cornstarch solution added to orange juice, water, and tea. Have them do a taste test of the liquids and discuss their feelings.

Audiovisual Supplements (available from MVRC):

Feeding. Videocassette. The Nursing Assistant Series. Medcom Inc., 1990. 10 min.

Activity Sheet Answers:

1. a. Offer the bedpan or urinal or assist the client to the bathroom.
   b. Wash the client's hands.
   c. Clean the dentures and place them in the client's mouth.
   d. Put sensory aids in place.

2. Elevate the head of the bed as high as the client can tolerate, in as close to a sitting position as possible with the overbed table positioned over the client.

3. Answers should include six of the following:

   - Check the name and room number before the tray is taken to the client.
   - Check the menu card to make sure all the items are provided on the tray.
   - Serve trays promptly on arrival so the food is the proper temperature.
   - Serve trays one at a time to prevent contamination of food.
   - Place the tray back in the serving cart or keep the tray warm in some way if the client cannot eat when the tray arrives.
   - Carry trays at waist level.
   - General appearance of the tray should be neat and orderly.
   - Place the main dish closest to the client.
   - Arrange items on the tray so the client can reach them.
   - Remove food covers and place them out of the way or take them back to the serving cart.
   - Open milk cartons, cereal boxes, or any other items that may be difficult for the client to open.

4. Answers should include five of the following:

   - Place the tray where the client can see the food.
   - Protect the client and bed linens with a towel or napkin.
   - Sit beside the client.
   - Don't rush the client.
   - Encourage the client to do as much as possible.

- Serve food in the order of the client's preference
- If the client cannot indicate a preference for the order in which food is served, alternate liquids and solids.
- Fill the spoon or fork about half full.
- Season the food as the client wishes.
- Warn the client about hot foods.
- Offer conversation.
- Wipe client's mouth at intervals during feeding.

5. a. Note the amount and type of food eaten.
   b. Take dirty dishes away as soon as possible.
   c. Wash the client's face and hands.
   d. Give oral care.
   e. Check clothing to make sure it is clean and free from spills.
   f. Assist the client to whatever activity he or she wishes to be involved in after the meal; for bedfast client, make him or her comfortable with the call device and place personal articles within reach.

6. a. Variety
   b. Flavor
   c. Taste
   d. Texture
   e. Color
   f. Cost

7. a. Place the client in a sitting position.
   b. Place the food in the side of the mouth that is not paralyzed.
   c. Remind the client to chew and swallow, if necessary.
   d. Give small amounts of food with each bite.
   e. Allow plenty of time for the client to chew and swallow.
   f. Clean the paralyzed side of the mouth out if necessary.

8. a. Identify all the food on the tray.
   b. Compare the placement of items to the position of the numbers on the face of a clock.
   c. Always place items in the same place at every meal.
   d. Warn the client about hot and cold food items.
   e. Indicate where eating utensils are placed.
   f. Open cartons and prepare the food.
   g. If the client must be fed, an oral prompt must be given to open his or her mouth; the food should be identified.
   h. Tell the client if a liquid is being given through a straw.

9. a. Become familiar with the facility's special procedures for serving trays to clients in isolation.

10. a. An intravenous infusion is a direct entry of fluid into a vein by means of a needle. The needle is attached to tubing leading to a bag or bottle of fluid. The fluid is ordered by the physician and contains essential nutrients, vitamins, or medications needed by the client.

b. If the drip has stopped or if it is running unusually fast, the supervisor should be notified. Redness, swelling, or pain at the insertion site should be reported. The tubing should have no kinks; the client should not be lying on the tubing. If the fluid is almost gone, the supervisor should be notified so a new one can be started. If the infusion is on an automatic pump and the alarm goes off, the supervisor should be notified. If the needle is accidentally pulled out, pressure is placed on the insertion site and the supervisor notified.

11. Place client in a sitting position or semi-Fowler's position if feeding is continuous. Observe the client for nausea, diarrhea, constipation, or complaints of feeling full. Make sure tubing is free from kinks. Place the feeding bag above the level of the stomach. A water-soluble lubricant can be placed on the nose where the tube is inserted. Oral care should be provided. The supervisor should be notified if the tube is accidentally pulled out.

12. Observe the client for nausea, diarrhea, constipation, or complaints of feeling full. Place the feeding bag above the level of the stomach. The supervisor should be notified if the tube is accidentally pulled out. When administering the feeding, check the position and condition of the tubing. Check the skin around the tube frequently for breakdown due to the leakage of liquid. Plug the tube when it is not in use.

Lesson 2: Intake and Output

Objectives:

1. Discuss the importance of fluid balance.
2. Identify the routes by which fluid is taken into the body.
3. Distribute drinking water.
4. Identify the routes by which fluid leaves the body.
5. Discuss the general considerations in measuring intake and output.
6. Measure and record intake and output.
7. Convert household measurements to metric equivalents.
8. Describe what is meant by frequent fluids and methods by which this can be accomplished.
9. Describe what is meant by restricted fluids and methods by which this can be accomplished.

Teaching Strategies:

1. Have the students monitor their own intake for 24 hours and compare the results in a class discussion.

2. Review measurement equivalents and how to convert between systems.

3. A simulation exercise can be set up in the laboratory. Different measuring devices can be filled with various amounts of liquid and placed at different stations, with a milk carton and a soda can used for intake and a bedpan, a Foley bag, and an emesis basin

used for output. The students should work through the stations, recording the amount as either an intake or an output and totaling up the amounts. Discuss the students' findings.

4. If the students are at the clinical site, assign them to work with a nurse assistant to measure intake and output.

Activity Sheet Answers:

1. If fluid is not balanced, the body will not remain healthy. Fluid is essential to life, since the body is approximately 65% water.

2. a. Drinking liquids and eating foods high in fluid content
   b. Intravenous infusion
   c. Nasogastric tube or gastrostomy tube

3. a. Urine
   b. Emesis
   c. Diarrhea
   d. Drainage from a wound
   e. Diaphoresis

4. On an intake and output record

5. A rigid container or graduate.

6. If the client is incontinent, the number of times the client voids is recorded on the I & O. Output in the form of emesis that is not caught in an emesis basin, wound drainage on dressings, and perspiration are also difficult to measure exactly. The number of times it occurs, the size of the area that is wet, and the wetness of the linens, clothing, or dressings are all ways that unmeasurable fluid loss can be recorded.

7. By measuring the amount of liquid contained in the most commonly used serving containers and keeping a list of the amounts

8. Cubic centimeters or cc

9. The client is encouraged to ingest more than his or her normal intake of fluids.

10. Answers should include three of the following:
    - Place fluids within reach.
    - Offer small amounts of fluid frequently.
    - Offer a favorite beverage or a variety of beverages.
    - Establish a goal for the amount of fluid to be ingested during each shift and communicate it to the client.
    - Offer foods high in fluid content.

11. The amount of fluid that should be ingested is limited.

12. Answers should include three of the following:
    - The total amount of fluid allowed is divided between the three shifts, with the day and evening shift being allotted the greatest amount of fluid.
    - Distribute the amount of fluid throughout the entire shift, giving more fluids at mealtime.
    - Offer frequent oral hygiene.
    - Allow the client to suck on ice chips, if allowed.
    - Hard candy can keep the mouth moist, if allowed.

Lesson 3: Weight and Height

Objectives:

1. Describe the types of scales that can be used to weigh clients.
2. Identify general considerations in weighing clients.
3. Convert a measurement of pounds into kilograms and one of kilograms into pounds.
4. Identify general considerations in measuring height.
5. Convert a measurement of inches into feet and inches and one of feet and inches into inches.
6. Measure client's weight and height.
7. Measure weight and length of infant.

Teaching Strategies:

1. Review the conversion of pounds to kilograms and vice versa, and the conversion of feet and inches to inches and vice versa.

2. Weighing devices in a health care facility may need to be pointed out and practice sessions with those devices may need to be done at the clinical site.

3. Demonstrate the procedures in this lesson and then allow students time to practice the skills.

4. If an infant scale is not available in the clinical laboratory to use for demonstrations, one might be borrowed from the obstetrics department of the local health care facility or from a pediatric physician's office.

5. If the students are at a long-term care facility, they can be assigned to work with a nurse assistant taking the monthly weights.

Audiovisual Supplement (available from MVRC):

Measuring Weight. Videocassette. The Nursing Assistant Series. Medcom Inc., 1990. 13 min.

Activity Sheet Answers:

1. a. Infant scale - type of balance scale with a platform large enough to lay an infant on
   b. Bathroom scale - used in the home to measure weight
   c. Upright scale - used to weigh ambulatory clients; has a platform where the client stands
   d. Wheelchair scale - special type of upright scale that has a platform large enough for a wheelchair
   e. Chair scale - scale in which the client sits in a chair to be weighed
   f. In-bed scale - may be a part of a mechanical lift or a special scale for those clients who are unable to be transferred out of bed

2. The physician may order medications and treatments based on the client's weight. Nutritional status can also be monitored by observing the client's weight.

3. Answers should include five of the following:
   - Use the same scale every time the client is weighed.
   - Weigh the client at the same time each day.
   - Take the client's shoes or slippers off; the client should have on as little clothing as possible.
   - The client should have the same type of clothing on every time he or she is weighed.
   - The best time to weigh a client is in the morning after he or she has urinated and before he or she has had anything to eat or drink.
   - Weigh an infant without clothing or diapers.
   - A brace or artificial limb should be weighed and that weight subtracted from the total weight.
   - Note if the client is weighed with a brace or artificial limb in place.
   - When using a wheelchair scale, weigh the wheelchair first, then put the client in it and weigh them both; subtract the wheelchair weight to get the client weight.

4. At least once every month

5. a. The large weight indicator indicates fifty pounds.
   b. The small weight indicator in smaller increments of pounds.

6. a. Assist the client onto upright or bathroom scales.
   b. If the client may not be able to maintain his or her balance, another type of scale should be used.
   c. Clients should not be left alone on chair, wheelchair, mechanical lift, or bed scales and should be taken off the scale as soon as the weight is recorded.
   d. Keep a hand close by infants when they are being weighed.

7. Measure height in bed by placing the client in a supine position on a flat bed. Position the end of a tape measure on the bed parallel to the top of the client's head and pull the tape down the length of the body to the soles of his or her feet.

8. Using either a tape measure or a measuring device on an infant scale

Answers to Written Evaluation

1. b
2. c
3. d
4. c
5. a
6. b
7. b
8. c
9. a
10. d
11. d
12. c
13. d
14. a
15. c
16. c
17. b
18. b
19. a
20. c
21. d
22. d
23. b
24. c
25. e
26. a
27. g
28. k
29. h
30. d
31. i
32. b
33. l
34. c

Unit VIII

Special Procedures

Overview of the Unit

This unit contains unrelated procedures, either diagnostic or treatment modalities. The "special" in the title has no significance other than that these procedures do not fit into any other category of activities for daily living. Included are admission, transfer and discharge; urinary elimination; bowel elimination; ostomies; specimen collection; applying heat and cold; wound care; and caring for the terminally ill and the deceased.

Lesson 1: Admission, Transfer and Discharge

Objectives:

1. Discuss the emotional impact that admission to a health care facility has on a client and his or her family.
2. Describe the nurse assistant's responsibilities when assisting with admission.
3. Identify the nurse assistant's responsibilities when transferring a client within a health care facility.
4. Discuss the nurse assistant's responsibilities when assisting with discharge.

Teaching Strategies:

1. Allow time for the students to complete the clinical/laboratory activity at the start of the lesson. Use their findings to begin the lesson by making a two column chart on the blackboard, with one column about feelings on admission and another about how to decrease anxiety and make the experience more comfortable. Relate the information gained from the students to the way clients feel.

2. Obtain an admission assessment sheet from a local health care facility to show to the students.

3. Role-play an admission with one student being a client and another being an admitting nurse. Have the other students identify what the admitting nurse did well and what could be improved.

4. If the students are at the clinical site, they can be assigned to work with a nursing assistant to do admissions, transfers and dismissals.

5. If the students are at an acute care site, they could be assigned to observe in the admissions office and assist with accompanying a client to a unit.

Activity Sheet Answers:

1. Answers will vary but should include many of the following:
   - Client feel insecure and unsafe because they are entering an unfamiliar environment.
   - Elderly clients may experience confusion on admission because of unfamiliar surroundings.
   - Clients may be unsure of what the future holds.
   - Clients must rely on health care workers to provide for their basic needs.
   - Clients are not given a choice regarding when meals are served, when tests are scheduled, or even when to bathe.
   - Clients may feel lonely and abandoned since family members will probably not stay with them all the time.
   - When admitted to long-term care facilities, clients experience many losses; homes, possessions, neighbors, and soical contacts and roles; which may cause them to feel sad, depressed, apathetic, anxious, demanding, or angry; family members may have similar feelings.

2. Answers should include five of the following:
   - Prepare the room so it is neat and clean; make the bed.
   - Label personal supplies with the client's name.
   - Obtain an admission pack if the facility has one.
   - Adjust lighting and ventilation for comfort.
   - Greet the client warmly.
   - Introduce yourself.
   - Find out how the client wishes to be addressed.
   - Observe the client closely; note any complaints to report to the supervisor.
   - Explain everything that the nurse assistant will do to the client.
   - Introduce the client to the roommate if the room is shared.
   - Show the client where to place belongings; offer to assist with unpacking and storing of belongings.
   - Make a list of belongings; mark client's belongings with their name (long-term care).
   - Put identification bracelet on.
   - Explain how to operate the call device, bed, lights, radio and TV
   - Explain meal schedules, visiting hours, and any other pertinent information.
   - Take vital signs and measure height and weight.
   - Collect specimens as designated by the supervisor.

3. Answers should include two of the following:
   - Explain to the client why he or she is being transferred
   - Give the client time to cope with their feelings about being transferred
   - Assist the client with packing belongings.
   - Send the chart and medical records with the client.
   - Introduce the client to the new staff.

4. Answers should include three of the following:
   - Assist the client with packing belongings.
   - Check all the drawers and closets.
   - Retrieve clothing in the laundry (long-term care).

- Dress the client appropriately for the weather.
- Make sure that all discharge instructions have been given by the charge nurse.
- Make sure that transfer papers accompany the client if he or she is going to another health care facility.
- Assist the client out of the facility.
- Follow the facility policy in cleaning the room.

Lesson 2: Urinary Elimination

Objectives:

1. Describe the characteristics of normal urine.
2. Discuss the factors that maintain urine elimination.
3. Identify conditions that may cause abnormal urine elimination.
4. Identify general considerations in giving and removing bedpans and urinals.
5. Assist client with urinal.
6. Assist client with bedpan.
7. Discuss the responsibilities of the nurse assistant in managing urinary drainage systems.
8. Change urinary drainage bag.
9. Discuss the nurse assistant's role in bladder training.
10. Change adult incontinent brief.

Teaching Strategies:

1. A urine-like substance can be made in the laboratory by adding varying amounts of yellow and red food coloring and ammonia to water. A little flour or corn starch added to the liquid will simulate cloudiness. Place various urine samples in the laboratory and have the students move from station to station and describe what they see and smell.

2. Students can be divided into three groups. Assign each group one of the disease processes; cystitis, nephritis, and renal calculi. Have each group research the topic and give a verbal report of their findings.

3. If the clinical laboratory does not have samples of the equipment from the lesson, (urinal, bedpan, catheters and drainage bags); check with a local health care facility to obtain samples for demonstration.

4. If the students are at the clinical site, they can be assigned to work with a nurse assistant to empty indwelling/Foley catheter bags.

Audiovisual Supplement (available from MVRC):

Techniques in Toileting and Personal Care. Videocassette. The Nurse Assistant Series, CA Medcom, Inc., 1990. 19 min.

Activity Sheet Answers:

1. Pale yellow (straw-colored), clear, with a slight ammonia odor; 200 to 300 cc's are voided an average of five to six times a day for a total of 1,000 to 1,500 cc's every 24 hours

2. 2,000 to 3,000 cc's

3. a. Stress incontinence - inability to control the passage of urine when pressure is placed on the bladder, such as by coughing, sneezing, laughing, exercising, or pushing on the abdomen
   b. Urge incontinence - inability to retain the urine long enough to get to the bathroom
   c. Neurogenic incontinence - caused by an injury or disease condition which interrupts the pathways of sensation, leaving the client with the inability to sense the urge to void
   d. Functional incontinence - caused by disease conditions or disabilities that affect the client's ability to recognize the need to void
   e. Dribbling - incontinence of small amounts of urine

4. a. Infection of the bladder
   b. Blood in the urine
   c. Inflammation of the kidney, usually caused by an infection
   d. Kidney stones that may block part of the urinary system
   e. Inability to empty the bladder completely

5. Answers should include two of the following:
   - Warm it prior to placement by running warm water in it and over the rim.
   - Sprinkle powder around the rim to decrease the friction on the client's skin and keep it from sticking to the client.
   - Elevate the head of the bed once the client is on the bedpan.

6. A catheter is a tube that drains urine from the bladder.

7. An external catheter is a condom-type sheath fitted over the penis and attached to a tubing system and drainage bag.

8. a. Straight/French catheter
   b. Indwelling/Foley catheter
   c. External or Texas™ catheter, or condom drainage

9. Answers should include six of the following:
   - Do not take the system apart unless the drainage bag and tubing need to be changed.
   - Keep the tubing free of kinks and make sure that the client is not lying on the tubing.
   - Coil the tubing on the bed instead of letting it hang below the level of the drainage bag.
   - Keep the drainage bag below the level of the bladder.
   - Keep the drainage bag from dragging on the floor by hanging it on the bed frame or chair.
   - Monitor the drainage in the bag to determine if the output is adequate.
   - Empty the drainage bag as needed.

- Keep the tip of the outlet tube from touching the floor when the drainage bag is emptied.
- Prevent pulling on the catheter tubing.
- Keep the urinary meatus clean and free of secretions.

10. Bladder training is the procedure of placing the client on the toilet, commode, or bedpan at specific times throughout the day and night so that the bladder becomes accustomed, or trained, to emptying at those intervals.

11. Answers should include two of the following:
    - Check the incontinent brief frequently.
    - Change it as soon as it is wet or soiled.
    - Give perineal care before a clean incontinent brief is applied.
    - Observe the skin for any signs of breakdown.

Lesson 3: Bowel Elimination

Objectives:

1. Describe characteristics of normal and abnormal stools.
2. Identify the factors that maintain normal bowel elimination.
3. Discuss abnormal bowel conditions.
4. Describe special measures that promote bowel functioning.
5. Discuss the general considerations in giving enemas.
6. Administer unmedicated enemas.
7. Describe bowel retraining.

Teaching Strategies:

1. A stool-like substance can be made from a variety of items, such as peanut butter, Play-Doh™ and white paste. By adding food coloring to the paste, different colors of stool can be simulated. Adding chocolate syrup to smooth peanut butter simulates the dark, tarry appearance and sweet smell of blood in a stool. Peanut butter (chunky works best) can be thinned with orange juice to simulate diarrhea. Different types of stool can be mixed and placed in bedpans at various stations around the laboratory. The students can move from station to station and identify the different characteristics of the stool found in the bedpan.

2. Have the students monitor their bowel habits for a week and then compare the results to see if there is a norm for the class.

3. Obtain some over-the-counter laxatives to show to the class.

Audiovisual Supplements (available from MVRC):

1. *Elimination, Specimen Collection, & Urinary Care.* Videocassette. The Nurse Assistant Series, CA Medcom, Inc., 1990. 34 min.
2. *Techniques in Toileting & Personal Care.* Videocassette. The Nurse Assistant Series, CA Medcom, Inc., 1990. 19 min.

Activity Sheet Answers:

1. Answers will vary but should include all of the following:
    - Light to dark brown in color
    - Soft and formed consistency
    - Frequency of movements, once or twice a day to every third day
    - Odorless or has the smell of decomposing food
    - Moderate in diameter

2. Answers should include four of the following:
    - Strong odor
    - Slightly sweet to highly odorous, rank smell indicating an infection
    - Sweet odor due to blood
    - Abnormal colors, such as green-tinged, yellow, gray, pasty white
    - Bright red streaks indicating bleeding
    - Dark, sticky stool indicating bleeding occurring high in the gastrointestinal tract
    - Undigested food, blood or mucus in the stool
    - Stool that is very large or very small in diameter
    - Liquid stool
    - Very hard stool

3. a. Diet containing fiber
    b. Fluid intake
    c. Physical activity
    d. Regular, daily waste elimination

4. a. Passage of unusually dry, hard stool
    b. Hard mass of stool that forms in the bowel and cannot be passed normally
    c. Frequent passage of liquid stool
    d. Varicose veins in the rectum
    e. Blockage in the bowel
    f. Inability to stop or control the passage of stool

5. Medications taken by mouth or in a rectal suppository form to promote peristalsis

6. Infusion of fluid into the rectum to stimulate the emptying of the bowel

7. a. Solution of tap water and a mild liquid detergent soap
    b. Solution of tap water and salt
    c. Enema of plain tap water

8. Sims' position - left lateral position
   Supine position with knees flexed and separated

9. Take a deep breath while the tubing is inserted and breathe deeply through the mouth during the procedure

10. Lower the enema to see if this relieves the cramping

11. If the client has severe cramps or pain that does not go away, starts perspiring heavily or feels faint

12. Bowel training is a program that is set up to assist a client in eliminating stool at a set time of day.

13. Digital stimulation is massaging the internal anal canal with a gloved, lubricated finger, which causes the colon to contract and promotes the passage of stool.

Lesson 4: Ostomies

Objectives:

1. Differentiate between types of ostomies.
2. Identify the general principles of ostomy care.
3. Change an ostomy bag.

Teaching Strategies:

1. Obtain appliances for classroom display and demonstration.

2. An ostomy simulator can be used as a model. If the clinical laboratory does not have one, check with the closest nursing school to see about borrowing a model. A local health care facility may have an ostomy nurse who has a model for educational purposes.

3. If the local or regional health care facility has a clinical nurse specialist who does ostomy care, ask him or her to speak to the class.

4. The Ostomy Society usually has ostomates who are available to speak to groups about their experiences.

5. Obtain pictures of ostomies that can be shown to the class from a medical-surgical nursing book.

Audiovisual Supplements (available from MVRC):

1. *Ostomy Care.* Videocassette. CA Medcom, Inc., 1993., 24 min.

2. *Preparing the Ostomy Client for Discharge*. Videocassette. CA Medcom, Inc., 1993. 18 min.

Activity Sheet Answers:

1. An ostomy is a surgically made opening through the abdominal wall into an organ.

2. a. Colostomy - an opening into the colon or large intestine
   b. Ileostomy - an opening into the ileum, a portion of the small intestine

3. a. Single barrel - has only one end of the bowel opening as a stoma on the abdomen
   b. Double barrel - has both ends of the bowel opening side by side as a stoma

4. a. Located on the right side of the body over the ascending colon
   b. Located across the midline of the body slightly below the waist
   c. Located on the left side of the body over the descending colon

5. a. Ureterostomy - a new opening on the abdomen for the ureter
   b. Ileal conduit - a section of the bowel that is removed and sewn together to make a small pouch. The ureters are placed into this newly created pouch and one end of this bowel pouch is brought to the surface of the abdomen and sewn there as a stoma.

6. a. Colostomy - opens into the bowel
   b. Ureterostomy- opens into the ureters of the urinary system

7. Answers should include the following:
   - Pink to light red in color
   - Moist like the mucous membranes of the mouth
   - Raised slightly off the abdomen
   - Skin around it smooth and free of irritation

8. A collection bag, called an appliance, is applied over the stoma to collect the drainage.

9. Irrigation is the introduction of a fluid into the stoma; it is similar to an enema. This procedure is used to train the bowel.

Lesson 5: Specimen Collection

Objectives:

1. Identify reasons why specimens may be ordered.
2. Identify general principles of specimen collection.
3. Identify frequently collected specimens.
4. Collect a midstream, clean-catch urine specimen.
5. Collect a 24-hour urine specimen.
6. Collect a sterile urine specimen from a catheter.

7. Collect a stool specimen.
8. Collect a sputum specimen.

Teaching Strategies:

1. Contact the local health care facility to see if specimen containers are available for demonstration purposes.

2. A medical technologist at a local health care facility may be available to come and speak to the class about specimen collection.

3. Check with the respiratory therapy department at the local health care facility to determine the availability of a speaker to discuss sputum specimens.

4. Demonstrate that keeping the lid on the container is important when collecting a 24-hour urine specimen to prevent evaporation and odors. Place a uncovered "specimen" consisting of ammonia and water in the room. The smell will diffuse throughout the room. To demonstrate evaporation, place a covered specimen containing the same amount of liquid in the room. The next day, compare the specimens and observe how much water has evaporated from the open container.

5. Assign students to a health care facility laboratory to observe how specimens arrive in the lab and how tests are performed.

Audiovisual Supplement (available from MVRC):

Elimination, Specimen Collection, & Urinary Care. Videocassette. The Nurse Assistant Series, CA Medcom, Inc., 1990. 34 min.

Activity Sheet Answers:

1. The results of these tests will aid the doctor in diagnosing an illness and evaluating the effectiveness of any treatment used.

2. By always washing your hands thoroughly before and after collecting a specimen.

3. Collecting a specimen that is not contaminated by anything outside of a client's body and one that is taken between the time a client begins to void and when he or she stops.

4. The initial urine specimen is thrown away and all urine is collected for the next twenty-four hours until the same time the following day.

5. a. About one to two tablespoons
   b. From different areas of the stool

6. One to two tablespoons

Lesson 6: Applying Heat and Cold

Objectives:

1. Identify safety measures to follow when applying heat and cold.
2. Identify the purpose and uses of heat application.
3. Identify the types heat applications.
4. Identify signs of complcations of heat application.
5. Apply warm, moist compress.
6. Apply warm, water bottle.
7. Apply aquathermia pad.
8. Identify the purpose and uses of cold application.
9. Identify the types of cold applications.
10. Identify signs of complications of cold application.
11. Apply ice bag or ice cap.

Teaching Strategies:

1. Obtain pictures of first degree burns to emphasize what can happen if heat is applied incorrectly.

2. Obtain equipment to demonstrate the procedures in the lesson. If the laboratory is not equipped with aquathermia pads, electric heating pads, or commercially prepared chemical packs, check with a local physical therapy department to see whether these may be borrowed. After demonstrating the procedures, allow the students time to practice manipulating the equipment in the laboratory.

3. Have one group of students apply an ice bag to their ankles and the other group apply a hot moist towel to their ankles. After five minutes, remove the packs and observe the skin for the normal changes. Each group should observe the effects of the temperature on the skin of the other group.

4. To demonstrate how the body adapts quickly to temperature changes, have students soak one hand in relatively warm water (105°F) for two to three minutes. Then, add the other hand to the same water and see which appears to be warmer.

5. (Role playing simulation of hot and cold applications). Have two to three students act as clients while one student is a nurse assistant. Apply an ice pack or warm soak to one "client" and immediately to another "client." While the "nurse assistant" is in the process of applying the second application, apply make-up to the first "client" to simulate one of the complications of heat or cold. (Make-up might be borrowed from the drama department or from local emergency services; used for simulation set ups.) The make-up should simulate how quickly "burns" might occur. Make-up can also be used to show various ages, from a very young child to an elderly person.

Audiovisual Supplement (available from MVRC):

Warm and Cold Applications: Applying a Soak. Videocassette. The Nurse Assistant Series, CA Medcom, Inc., 1990. 10 min.

Activity Sheet Answers:

1. Answers should include six of the following:
    - Check applications frequently.
    - Maintain all electrical devices in good operating condition.
    - Maintain all equipment that uses water in good operating condition.
    - Use correct temperature levels and check levels frequently.
    - Monitor application time accurately.
    - Provide comfort and privacy during application.
    - Place call device within the client's reach.
    - Know how to operate any type of equipment that is to be used for the treatment.
    - Keep metal or plastic parts of equipment away from a client's skin.
    - Take extra precautions when caring for an unconscious client.

2. The first check should be made five minutes after the initial application and then as requested by the supervisor.

3. Unconscious clients have no way of telling the nurse assistant that he or she is experiencing discomfort. Close monitoring of the client's body area being treated is critical in preventing burns.

4. When heat is applied to the body, it causes the blood vessels to dilate and bring more blood to the area.

5. Answers should include two of the following:
    - To relieve or reduce pain
    - To relax muscles which may be in spasm
    - To reduce inflammation
    - To provide warmth and comfort

6. The effects from any type of moist heat are greater and will occur much faster than with a dry application. Heat will also penetrate deeper with a moist application so applications should be checked frequently to prevent thissue damage.

7. Because dry heat does not penetrate as deep as moist heat, the risk of burns is somewhat decreased. However, higher temperatures are used to gain the desired effect, so the risk of a burn remains.

8. Answers should include four of the following:
    - Compresses
    - Packs
    - Soaks
    - Tub soaks

- Sitz bath
- Water bottles
- Aquathermia pad
- Electric heating pad
- Commercially prepared chemical packs

9. a. Pain or sensitivity at the site
   b. Too much redness (darker discoloration)
   c. Blisters

10. When cold is applied to the body, it causes the blood vessels in the area to constrict (become narrow) and thus reduces the circulation to that area.

11. Answers should include two of the following:
    - To control bleeding by blood vessel constriction
    - To prevent swelling or fluid accumulation in the tissues
    - To reduce or relieve pain by the numbing effect
    - To cool the body when a high fever is present

12. The effects from any type of moist cold are greater and will occur much faster than with a dry application. Cold moist applications will also penetrate deeper than dry applications, so applications should be checked frequently to prevent tissue damage.

13. Because dry cold does not penetrate as deep as moist cold, the risk of tissue damage is somewhat decreased. However, longer applications times are used to gain the desired effect, so the risk of tissue damage remains.

14. Answers should include four of the following:
    - Compresses
    - Packs
    - Soaks
    - Tub bath
    - Ice caps or ice collars
    - Water bottles
    - Commercially prepared chemical packs

15. a. Pain
    b. Cyanosis (bluish or purplish skin color)
    c. Burns and blisters

Lesson 7: Wound Care

Objectives:

1. Describe types of wounds and lesions.
2. Identify characteristics of wounds and their drainage.

3. Discuss basic wound care.
4. Perform clean, nonmedicated dressing changes.
5. Describe the main cause of pressure ulcers.
6. Identify the common sites where pressure ulcers are most likely to develop.
7. Identify clients who are most prone to developing pressure ulcers.
8. Describe ways the nurse assistant can help prevent pressure ulcers.
9. Discuss the stages of the development of pressure ulcers.
10. Give pressure ulcer care.

Teaching Strategies:

1. Ask a wound care specialist, either a physician or a clinical nurse specialist, that works at a local health care facility to come and speak to the class.

2. Obtain pictures of the different types of wounds and lesions. Most assessment books contain colored pictures of them; a medical-surgical nursing book is another possible source.

3. Obtain wound care protocol from a local long-term care facility to share with the class.

4. The pharmaceutical companies who sell wound care products often have free samples and colored pictures of the stages of pressure ulcers. They may also have videos available for loan, purchase or as give-aways.

5. Obtain different types of dressings and tape for classroom demonstration.

6. A local long-term care facility may have a treatment nurse who is responsible for doing dressing changes on wounds. The students may be assigned to observe.

Activity Sheet Answers:

1.
   - Wound - a physical injury involving a break the skin, either accidental or deliberate
   - Lesion - a change in the skin due to a disease or allergic condition

2.
   a. Surgical wound which is a deliberate cut
   b. Wound caused by scratching or by any means where portions of the skin are scraped away
   c. Shearing open of the top layers of skin when the skin is accidentally twisted or bumped
   d. Lesion that is filled with pus and has an inflamed base
   e. Area of dried body secretions over a lesion
   f. Raised area filled with clear tissue fluid

3.
   a. Yellow - dried tissue fluid
   b. Scab - dark red crust; an accumulation of blood cells and tissue fluid
   c. Necrotic - crust is black, indicating that the tissue is dead

4. Clear to slightly yellow fluid or blood

5. Drainage will be greenish and have an odor; tissue surrounding the wound will be red and slightly warm to the touch and may also look puffy or swollen.

6. Step-by-step procedure that indicates what should be done if the client cuts or tears the skin

7. a. Sterile dressings - all supplies are free of bacteria
   b. Clean technique - dressing is kept as free as possible from contamination by bacteria

8. Put it in a paper or plastic bag before disposing of it in the trash.

9. Pressure sores develop when skin and tissues underneath are injured due to a lack of blood flow; the lack of blood flow occurs because of continuous pressure on the skin over a bony prominence.

10. Answers should include four of the following:
    - Coccyx
    - Hipbones
    - Ridges of the spine
    - Heels
    - Shoulder blades
    - Ankle bones
    - Back of the head
    - Elbows

11. a. Stage I - Skin is red and tender and may be slightly warm to the touch.
    b. Stage II - Skin becomes bluish in color, with a mottled appearance; top layers may be blistered or broken and drainage of tissue fluid may be present.
    c. Stage III - An open sore is visible, with all layers of skin involved.
    d. Stage IV - Destruction of tissue extends down to muscle and/or bone.

12. Answers should include two of the following:
    - Elderly who have poor circulation, may be malnourished, and have impaired mobility
    - Paralyzed clients who cannot move and may have sensory deficits
    - Thin and malnourished clients
    - Obese clients
    - Incontinent clients

13. Answers should include four of the following:
    - Check skin frequently for signs of pressure ulcers.
    - Change client's position at least every two hours.
    - Massage bony prominences gently.
    - Perform passive and active exercises.
    - Keep skin clean and dry and bed linens free from wrinkles and other irritating substances.
    - Change incontinent clients frequently.
    - Encourage proteins, vitamins, and minerals in the diet.
    - Drink adequate fluids.

- Put antipressure devices on the bed.

Lesson 8: Working with the Terminally Ill

Objectives:

1. Identify general principles of caring for the terminally ill.
2. Describe the signs of approaching death.
3. Identify the changes the body undergoes after death.
4. Discuss the care of a body after death.
5. Perform postmortem care.

Teaching Strategies:

1. Many of the studeunts have not been exposed to a dying person or to a dead body. For those who wish to do so, a trip to the morgue could be arranged so the students can see and touch a dead body. Some students may want to watch an autopsy, if arrangements can be made for one to be done during the student's clinical time.

2. Try to arrange a tour of a local funeral home and ask the director for suggestions on how to prepare the body for transport. Also, he or she may share advice on how to help the client's family during this time.

3. Obtain copies of advance directives from a local health care facility to share with the class.

4. A speaker from a hospice care program could be asked to come in and speak to the class.

Activity Sheet Answers:

1. The nurse assistant should be aware if a client has advance directives and support the wishes of the client.

2. Hospice care is a program of care that allows a dying client to remain at home and die there.

3. Answers should include six of the following:
   - Keep them as comfortable as possible.
   - Handle the client's skin gently.
   - Change the client's position frequently.
   - Keep linens clean and unwrinkled
   - Give frequent mouth care.
   - Elevate the client's head slightly and assist in removing secretions from the mouth.
   - Monitor elimination.
   - Keep the client warm.
   - Give small portions of food more frequently.
   - Offer liquids at routine intervals.

4. Answers should include six of the following:
    - Varying level of consciousness
    - Glassy appearance to eyes and the gaze may be fixed and staring
    - Loss of movement, muscle tone, and sensation
    - Incontinence
    - Legs and feet feel cool to the touch
    - Very pale and cyanotic or mottled skin
    - Light film of perspiration on the skin, making it feel clammy
    - Fast, weak, and irregular pulse
    - Falling blood pressure
    - Slow respirations slow or Cheyne-Stokes breathing
    - Dropped jaw; mucus collects in the client's throat, causing a rattling sound

5. a. Permanently dilated pupils
    b. Body feels cold
    c. Client may urinate, defecate or pass flatus if turned or positioned
    d. Bluish-purple color in dependent body parts from blood pooling in them
    e. Rigor mortis occurs four to eight hours after death

6. Answers should include three of the following:
    - Elevate the head slightly.
    - Keep the body flat on its back with arms and legs straight.
    - Clean the body, removing secretions and reinforcing dressings if drainage is present.
    - Close the eyes.
    - Place the dentures in the mouth, if possible.
    - Cover the body with a sheet.

7. Answers will vary but should include all of the following:
    - Notify the home health agency and the funeral director.
    - Someone must pronounce the client dead.
    - Give emotional support to the family.

Answers to Written Unit Evaluation

1. b
2. d
3. d
4. a
5. c
6. b
7. d
8. b
9. c
10. a
11. b
12. d
13. a
14. b
15. c
16. a
17. d
18. c
19. c
20. b
21. a
22. l

23. k
24. g
25. d
26. i
27. m
28. h
29. c
30. d
31. j
32. c
33. h
34. l
35. f
36. a
37. i
38. e
39. b
40. f
41. c
42. i
43. d
44. b
45. g
46. d
47. b
48. c
49. a
50. c
51. b
52. a
53. a
54. a
55. c
56. b
57. d
58. c
59. c
60. a
61. d
62. a
63. c
64. a
65. d
66. d
67. b
68. b
69. a
70. c
71. b
72. a
73. h
74. g
75. m
76. d
77. j
78. n
79. e
80. a
81. k
82. c

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Nurse Assistant

in Acute, Home Health and Long-Term Care Settings

Student Manual

Instructional Materials Laboratory - University of Missouri-Columbia
Missouri Department of Elementary and Secondary Education

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Nurse Assistant Competency Record

Nurse Assistant in Acute, Home Health and Long-Term Care Settings
Certificate of Achievement

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Foreword

This *Nurse Assistant in Acute, Home Health and Long-Term Care Settings* manual is designed to be used by students who are in secondary health occupations programs. A clinical site is needed for individuals to practice nurse assistant skills and to demonstrate mastery of these skills.

This manual is divided into eight units: Introduction to Nursing, Employment, Interpersonal Relationships and Communication Skills, Safety, Personal Care, Restorative Nursing, Nutrition and Special Procedures. Units are further divided into lessons, which contain lesson objectives, key terms, content information, illustrations, and activity sheets as appropriate for the content. Activity Sheets are designed to assist the learner in mastering the information in each lesson. The Clinical/Laboratory Activities included on the Activity Sheets should be reviewed or discussed with the instructor or clinical supervisor upon completion.

Each unit has a written evaluation that should be taken after all lessons in the unit are studied. A score of a least 80 percent indicates that the student has satisfactorily completed the unit and may proceed to the next unit. Students should review any lessons or materials that correspond to missed evaluation items. The student should practice the skills outlined in the lessons before requesting evaluation of the skills. Not all lessons contain steps of procedure. The clinical supervisor will be evaluating mastering of the skills.

A Unit Checklist, located at the end of each unit, provides a method for keeping track of Activity Sheets, Skill Sheets, and the Written Unit Evaluation to be completed in the unit.

The Written Unit Evaluations and Skill Sheets are included at the end of the manual. If you are taking this instruction under the supervision of an instructor or clinical supervisor, these pages may be removed from your manual. When you are ready to complete a Written Unit Evaluation or a Skill Sheet, check with your instructor or clinical supervisor.

Those using this manual on an individual basis may want to order the Instructor's Manual, which provides answers to Activity Sheets and Written Unit Evaluations.

Prior to beginning this manual, the student should successfully master all competencies in the *Health Care Assistant Core* curriculum. The *Health Care Assistant Core* curriculum is designed to teach information and skills common to all health care workers.

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Glossary

A

accredited - meets standards set by a national professional organization to improve patient outcomes in acute care facilities

acquired immunodeficiency syndrome (AIDS) - the last stage of an HIV infection when symptoms appear

active-assistive ROM exercises - range of motion exercises where a client moves as independently as possible and the nurse assistant does range of motion for joints that the client cannot move or has difficulty moving

active ROM exercises - range of motion exercises a client does without assistance

active-assisted transfer - a transfer in which a client can provide some help *(see dependent transfer)*

activities director - health care team member who specializes in activity planning and coordination

activities of daily living - activities done on a daily basis as part of life

administrator - health care team member who is responsible for all aspects of the operation of the health care facility in which care is being given

agitation - an inappropriate verbal or motor activity by a person and may include such behavior as pacing, cursing, screaming, biting, or hitting; may be due to physical, mental or emotional causes

airborne precautions - isolation precautions used when the infectious agent is carried in the air and can be inhaled

alarm phase - reaction to stress in which the body gears up to fight or flee the demand

alignment - when body parts are positioned so that the body can function at its best and is most comfortable

ambulation - walking clients to help them remain physically active

anticoagulants - medications that delay the clotting of the blood

antidote - substance which counteracts the effect of poison in the body

anxiety - an emotional state charcterized by a feeling of apprehension or unease

application - a form to be filled out when requesting a job after personal or telephone contact is made with the facility

arthritis - an inflammation of a joint

assessment - gathering information about a client

assistive walking devices - aids such as cane, cruthes and walkers tha clients use for support when they ambulate

atrophy - the shrinking and loss of muscle strength

B

bathroom scale - a type of scale used in the home to weigh a client

behind-the-ear aids - hearing aids having a piece that fits in the ear with a channel that connects to a piece placed behind the ear

biological/ infectious hazards - hazards that involve infectious agents transmitted by contact with infected clients or contaminated bodily secretions

blanch - whitening of normal skin when pressed

body-worn aids - hearing aids having a piece placed in the ear connected by a cord to the sound amplifier that looks like a small radio or cassetee recorder; the amplifier is placed in a pocket or clipped on a belt

bolsters or wedges - foam-filled positioning aids used to elevate the trunk or other parts of a client's body

brace - a support for weakened muscles or joints, or immobilization of an injured body part; usually made of formed plastic with Velcro™ fastenings or of leather and metal supports

C

caries - tooth decay

case management - registered nurse coordinates the care provided by all members of the health care team; newest way to organize nursing care

Centers for Disease Control and Prevention (CDC) - a division of the United States Department of Health and Human Services that deals with the prevention and control of infectious diseases

central line - an IV inserted into a large vein, such as the subclavian or the superior vena cava for a long period of time

centralized system - care delivery system in which the lines of authority are direct from top to bottom

certified medication technician (CMT) - health care team member who prepares and administers selected medications, transcribes physicians' orders, observes and reports effects of medications, and assists with resident care

certified facility - an agency that meets the minimum standards set forth by the federal government for Medicare and Medicaid reimbursements

chair scale - a type of scale that has a chair in which the client sits; it may be either a balance or an electronic scale

chemical hazards - hazards presented by chemicals, such as medications, aerosols, vapors, and solutions, that are potentially toxic or irritating to a body system

client teaching - giving information to clients that will enable them to manage their health care needs and to be as independent as possible in their own care

closed bed - an unoccupied bed in which the top linens are spread to cover the bottom linens to protect them from the accumulation of dust in the environment

complete bed bath - a bath that involves washing the total body while a client is in bed

confidentiality - keeping client information private

contact precautions - isolation precautions used when the infectious agent is transmitted either directly (through body to body contact) or indirectly (through an intermediate object)

contracture - a deformity of a joint caused when strong muscle groups in a body part contract or draw into a fixed position

crisis intervention - when a health care worker steps into a situation with the intent of resolving an immediate problem by decreasing the stress produced by the sudden event and by identifying resources to assist the client in coping with the situation

crisis - a significant moment or event in a person's life or during an illness that has an emotional or physical effect on the individual

culture - the set of values, beliefs, attitudes, and social behaviors that a group of people share and pass down from one generation to the next

customer - someone who is purchasing a service and has a right to expect that service to be of high quality

D

decentralized system - care delivery system in which responsibility for power and authority has been delegated to lower levels in the organization

defense mechanisms - specific behaviors or techniques that combat feelings of discomfort or threats; used to deal with difficult situations

dehydration - a condition resulting when intake is less than output

demanding client - a client who attempts to exert control over a situation by "bossing" everyone, asking for help repeatedly, and requesting priority status for receiving care

dependent transfer - a transfer that requires the assistance of at least one other person; either active-assisted or passive-assisted

depression - a prolonged feeling of sadness and hopelessness

developmental crisis - a crisis that relates to a person's stage of life

disability - a mental, physical, or social condition that makes a person incapable of functioning independently

diversity - the condition of being different

documentation - the recording or charting of information about the client in a permanent record

draw sheet - a sheet made of plastic or cotton placed crosswise in the middle of a bed over the bottom sheet to protect the bedding from soiling; cotton draw sheet also used for moving or turning a client *(see lift sheet)*

droplet precautions - isolation precautions used when the infectious agent is transmitted in droplets (through sneezing, for example) to the mucous membranes of another person

dry shampoo - a commercial preparation, usually foam based, that absorbs the excess oil and accumulated dirt in the hair; given to clients who cannot move out of bed

dysphagia - difficulty swallowing

E

economic diversity - a wide range of income levels in the population

edema - a condition resulting from fluid storage in body tissues due to a greater fluid intake than output

emotion - a feeling that has both psychological and physical aspects; love, anger, and fear are emotions

employee rights - knowledge and/or privileges that a worker can expect from his or her employer

environmental/mechanical hazards - elements in the work environment that can cause accidents, injuries, strain, or discomfort

ergonomic hazards - hazards related to the design or modification of a workplace to match human characteristics and capabilities

exhaustion - reaction to stress when symptoms occur; the body takes control and "makes" the person sick so they are removed from the demand

external stressor - a stressor that comes from the environment

eyeglass aids - hearing aids that attach to the earpiece of a pair of eyeglasses

F

flossing - the use of a specially waxed or unwaxed string to remove particles of food from between the teeth and to stimulate the gums

flow sheet - a sheet on which daily information about a client is checked or charted

fluid intake - the ingestion of water

fluid output - elimination of fluid from the body in the form of urine, perspiration, feces, and moisture exhaled from the lungs during respiration

footboard - a positioning aid that is a padded, upright board placed at the foot of the bed to give the client a solid, flat surface against which to rest his or her feet; also prevents footdrop

footdrop - the flexion of the foot downward

foreskin - the loose skin over the head of the penis

four-point gait - a walking pattern for a client who can bear partial or full weight on an affected extremity; the four points are both feet and two crutches

frequent fluids - a client is encouraged to ingest more than his or her normal fluid intake

full-service provider - an institution which provides care from diagnosis to treatment

functional nursing - care is divided by tasks among the members of the team

G

gait belt - a special transfer belt made of heavy cotton cording that is placed around a client's waist and provides a handle by which to lift, maneuver and hold onto the client

gastrostomy (G) tube - a tube that is surgically inserted directly into the client's stomach for the purpose of delivering liquid nourishment when a client can no longer swallow/ to be used for a long period of time or the rest of a client's life

general adaptation syndrome - consists of the general physiological processes the body goes through to maintain life

graduate or graduated cylinder - a tall narrow container with a volume scale

group - two or more people

group dynamics - the way the members of the group interact

H

halitosis - bad breath

hazard - any source of danger

hemiparesis - paralysis of one side of the body, either right or left; can occur with a stoke

hepatitis B (HBV) - an infectious contagious disease of the liver that produces flu-like symptoms; caused by a virus found in the body fluids of an infected person

home health aide - nurse assistant working in home health

home safety plan - a plan establishing what each person in the home will do if an emergency occurs

home health care - a community agency that delivers care and services to people in their homes

hospital - an inpatient health care agency

human immunodeficiency virus (HIV) - a virus that attacks cells in the body and eventually impairs the body's immune system; spread by contact with infected blood or other bodily fluids

hyperalimentation - a highly concentrated solution of nutrients

I

in-bed scale - a type of scale used for those clients who must remain on bed rest or whose condition does not allow them to be transferred out of the bed

incident - any act or situation that occurs in which a client is injured or has a potential for injury, or that has legal implications

incident report - a written account of what happened prior to, during, and after an incident; most health care facilities have a form on which the information is recorded

independent transfer - a transfer that a client can do without any direct assistance from another person

infant scale - a type of balance scale with a platform large enough to hold an infant

infestations - the presence of parasites on the skin or in the hair

initial assessment - the information gathered when a client enters a health care facility

initiation phase - phase of a group in which group members determine relationships, identify goals and purposes of the group, and each member takes on a role

intake and output record (I & O sheet) - a form kept at the client's bedside on which intake and output measurements are recorded

intermediate care facility - a facility that provides 24-hour room, board, personal care and basic health and nursing care services under the daily supervision of a licensed nurse and the direction of a licensed physician

internal stressor - a stressor that comes from within a person

interpersonal relationship - a relationship that develps between people in a group

interpersonal stressor - a stressor that comes from demands made by other people

interview - an appointment to speak with a potential employer

intrauricular aids - hearing aids that are worn in the ear

intravenous infusion - direct entry of fluid into a vein by means of a needle

isolation precautions - specific procedures and precautions designed to prevent a client from infecting others or being infected by others

J

job description - states the activities and responsibilities of the nurse assistant

L

lap robe - a small blanket that fits over the lap

leader - the person responsible for guiding a group and ensuring that its task is complete

licensed practical nurse (LPN) - health care team member who must practice under the direction of a registered nurse or a licensed physician; the LPN assists in planning, assigning and evaluating nursing care

licensed facility - meets minimum standards set by the state

lift sheet - a standard bedsheet folded in half and placed across the center section of a bed under a helpless or unconscious client's trunk, from shoulders to hips, to assist in moving or positioning the client *(see draw sheet)*

lines of authority - the decision-making levels within a health care setting

long-term care facility - an inpatient health care facility that provides care for those who are unable to care for themselves. Such a facility may be referred to as a nursing home or an extended care facility.

M

maintenance function roles - roles within a group that help the group work together, promoting unity and keeping the group encouraged and on task

mechanical lift - a device used for transferring clients who are too heavy to lift; a client sits in a sling supported by an arm and frame and a crank or lever raises or lowers the arm and frame to transfer the client

medication resistant - organisms that have been able to change their structure so that the antibiotic no longer harms or kills them

Minimum Data Set (MDS) - a document used by nursing staff to compile assessment findings on each resident in a long-term care facility; a component of an RAI

mottled - irregular bluish-purple patches on the skin that feel cool to the touch

multidrug-resistant - organisms that have developed a resistance to many different antibiotics

N

nasogastric (NG) tube - a tube passed through the client's nose and down the esophagus to the stomach that provides liquid nourishment; either continuously or intermittently

natural disasters - disasters caused by the forces of nature

nosocomial infections - infections acquired in a health care facility

nurse assistant - health care team member who provides for and assists clients with activities of daily living; the nurse assistant's responsibilities are determined by the health care setting in which he or she works

O

objective observations - facts about a client that are gathered using one's senses

Occupational Safety and Health Administration (OSHA) - the federal agency that sets health and safety standards to protect employees

open bed - an unoccupied bed in which the top linens are fanfolded

oral hygiene - the care of the teeth, gums and inside surfaces of the teeth and mouth

orange stick - a short, round stick with one end pointed and the other beveled; it is best for cleaning under the client's nails

organizational chart - a diagram or listing of the employee positions and their level of authority

orthostatic or postural hypotension - a rapid change in position causing blood pressure to drop and leaving a clietn feeling light-headed and dizzy; moving to quickly from a lying to a sitting position

overdependence - an extreme reliance on health care personnel; may occur when clietns feel they cannot cope with the current situation

P

paraplegia - paralysis of the lower extremities

partial bed bath - a bath that involves washing only the face, hands, axillae, and perineal area while a client is in bed

passive-assisted transfer - a dependent transfer in which a client cannot help in any way and completely depends on others to do the work *(see dependent transfer)*

passive ROM exercises - range of motion exercises performed by a nurse assistant on a client who does not help in any way

peribottles - squeeze bottles filled with cleaning solution

perineal care (peri care) - the washing of a client's genital and rectal areas of the body

perineum - the tissue of the perineal area

personal care activities - activities that involve caring for the human body ; activities of daily living

physical hazards - agents in the work environment that can cause tissue trauma

physician - health care team member who makes the diagnosis and gives the orders for medication and treatment

plaque - a sticky, transparent, bacterial film found on the teeth

pneumonia - an inflammation of the alveoli in the lungs caused by organisms that can be bacterial, viral, or fungal in nature

podiatrist - a physician trained in foot care

poisoning - ingestion of any substance which is harmful to the body

postural hypotension - *(see orthostatic hypotension)*

prejudice - an attitude, opinion, or feeling about someone or something that is based upon preconceived ideas or supposed characteristics

primary nursing - care provided by an all registered nurse staff; the primary nurse is assisted by associate nurses who care for clients in the primary nurse's absence

problem-solving process - a six-step process that can help in making decisions

prothesis - an artificial device used to replace a missing part of the body; most common prothesis is a limb, either an arm or leg

psychosocial hazards - factors or situations that may cause stress, emotional strain, and/or interpersonal problems

Q

quadriplegia - paralysis of all four extremities

R

range of motion (ROM) exercises - exercises that move the joints of the body through their normal pattern of movement

reference - someone who knows an applicant well and can speak positively about his or her personal characteristics and work history

registered nurse (RN) - health care team member who plans, assigns, and evaluates nursing care; the RN is responsible for coordinating all nursing care and for making sure the quality of care is acceptable

regulated medical waste - blood, blood products, sharp medical instruments, and dressings contaminated by body fluids

religious diversity - many different religions; in America, everyone has the freedom to practice the religion of their choice

Resident Assessment Instrument (RAI) - form used by the whole health care team at a long-term care facility to provide information about each resident and to establish treatment goals

residential care facility - a long-term care facility that provides room, board, basic personal care and 24-hour protective oversight for clients who do not require nursing services but cannot live independently because of physical or mental limitations

resident - a client at a long-term care facility

resistance phase - reaction to stress for a short period of time in which the body tries to balance the need to work faster with some conservation measures to help it keep going to handle the demand

resistive ROM exercises - range of motion exercises done by a client who moves the joint through its range of motion as a nurse assistant provides pressure resistance

restorative aides - health care team member who works under the direction of a physical therapist to provide ambulation, transfer and other mobility assistance to residents in long-term care

restricted fluids - the amount of fluid that should be ingested is limited to a certain amount, which is usually ordered by a physician

resume - a typewritten summary of information about educational and work history

risk management - the recording and tracking of all existing or potential hazards within a workplace and establishing policies and procedures to deal with these hazards if or when they occur

S

sandbags - a positioning aid that is used to immobilize a body part; they are heavy and hard for a client to dislodge accidentally

self-oriented roles - roles within a group in which group members seek to meet their own needs rather than those of the group

shower bath - a bath given in a shower with the client either standing up or sitting in a chair; may be preferred for clients who have difficulty with mobility or getting into and out of a bathtub

situational crisis - a crisis that may occur at any point in a person's life and is precipitated by an extremely stressful event

skilled nursing facility - a long-term care facility that provides 24-hour room, board, skilled nursing care, and treatment under the supervision of a registered nurse and the direction of a licensed physician

sliding board - a smooth, varnished wooden or vinyl board about one foot wide and two feet long used to transfer a client; for clients who can maintain their balance in a sitting position but are too weak to stand up

sling - a cloth device to cradle an injured or paralyzed arm or hand; helps a client maintain balance when transferring and ambulating

standard precautions - isolation procedures that should be used with every client whether or not an infectious organism has been identified; every client is treated as if he or she is potentially infectious

stereotype - an assumption that all persons from a particular culture or background will act in a certain way

stress - the body's response to the demands of life

stressor - a demand made on the body; can be positive or negative

subjective observations - one's opinions about a client

surgical bed - the bed prepared for a client returning from surgery; a surgical bed has extra protective linen on it, and it is left in the high position to accommodate the transfer of a client from a gurney

T

task function roles - roles within a group that relate to what the group must accomplish

team nursing - a team leader, usually a registered nurse, takes responsibility for organizing and coordinating care of a clients; under this team leader, registered nurses, licensed practical nurses, and nurse assistants share the responsibility of caring for clients assigned to their team; most common way to organize nursing care

termination phase - phase of a group that occurs after tasks (goals of the group) are complete

three-point gait - a walking pattern for a client who is nonweightbearing or partial weightbearing; the three points are the two crutches and the unaffected foot

therapeutic relationship - a relationship that develops between a health care worker and a client; the client must be helped and must feel better due to the interaction

toe pleat - an extra fold in both the top sheet and the bedspread made to prevent restriction of circulation and foot drop

transferring - the moving of clients or helping them to move from one place to another

transmission-based precautions - isolation procedures used for clients that are known to be infected or for those suspected of having an infection

trapeze - a triangular grab bar that hangs above a client's chest within reach to help the client move or reposition

tub bath - a bath given in a regular bathtub to clients who are mobile and may prefer the greater relaxation of being partially submerged in water

tuberculosis (TB) - an infectious bacterial disease spread by airborne droplets when an infected person coughs, sneezes or laugh; organism implants itself in the lung, causing inflammation

U

unit secretary - health care team member who is responsible for the paperwork functions of the nursing unit

upright scale - a type of scale which has a platform on which the client stands; the weight indicators are moved until the scale balances

W

wedges - *(see bolsters)*

wheelchair scale - a special type of upright scale that has a platform large enough to accommodate a wheelchair

whirlpool tub bath - a bath that requires a special whirlpool tub with a chair that mechanically lifts a client into the tub; the client remains seated during the bath; the tub is powered to create a whirlpool action for greater cleansing

working phase - phase of a group which involves problem-solving and the achievement of the goals of the group

Unit I

Introduction to Nursing

Nursing is an exciting field. There are many different settings in which to practice and multiple tasks to be done. The desire to work with people of all types is an essential trait for those people wanting to work in the profession.

Once employed, the nurse assistant must know the lines of authority, the scope of practice, and how to be an efficient worker. This unit covers information that will assist the prospective nurse assistant to be successful in the health care industry.

Unit Lessons

The Health Care Industry

Being an Efficient, Effective Practitioner

Lesson 1:
The Health Care Industry

Objectives:

A. Identify types of health care settings.

B. Identify the health care team members and each of their roles.

C. Identify the basic tasks of a nurse assistant.

D. Define the role of a nurse assistant in acute, long-term and home health care.

E. Differentiate between the types of health care insurance.

F. Identify the impact of regulatory agencies on the health care industry.

G. Identify current trends in the health care industry.

H. Identify community resources that a client can utilize with or without assistance.

Key Terms:

- Hospital
- Full-service provider
- Long-term care facility
- Resident
- Intermediate care facility
- Skilled nursing facility
- Residential care facility
- Home health care
- Physician
- Administrator
- Registered nurse
- Licensed practical nurse
- Certified medication technician
- Nurse assistant
- Unit secretary
- Restorative aide
- Activities director
- Job description
- Home health aide
- Licensed facility
- Certified facility
- Accredited

The health care industry is changing rapidly. At one time the hospital was the base of the health care delivery system. Care is now being done in the community, from home health agencies, nurse-managed clinics, and school-based health clinics, with the majority of services being provided through an outpatient-based delivery system. The impact of regulatory agencies and insurance reimbursement has led to a great deal of the change. At one time nursing personnel could concentrate on providing direct client care. Now, all who come in contact with the client must be able to help that person move through the health care system and get the best "fit" for his or her needs with the services provided in the community. For example, a client requiring a hip replacement would have surgery at the hospital, then he or she might go to a long-term care facility for six weeks for rehabilitation. Once home, the client might have a home health aide to assist with personal care until full mobility is regained. Throughout this manual, the term client is used to refer to the person receiving care regardless of the health care setting.

Types of Health Care Settings

The **hospital** is an inpatient health care agency. Hospitals may be small or large, depending on the needs of the community. They may be privately owned, part of large corporations, or run by the government. Some hospitals operate for profit, others on a not-for-profit basis. Most are **full-**

Figure 1.1 - Departments within a Hospital

NURSING	ANCILLARY	DIAGNOSTIC/TREATMENT
• Medical Nursing • Surgical Nursing • Pediatric Nursing • Obstetrical Nursing • Emergency Room • Operating Room	• Dietary • Housekeeping • Maintenance • Business Services • Volunteer Services • Social Services • Public Relations • Central Supply • Medical Records	• Pharmacy • Radiology • Pathology • Laboratory • Physical Therapy • Occupational Therapy • Respiratory Therapy

service providers. When a client enters the institution, his or her entire care from diagnosis to treatment can be provided by that institution. Due to the high cost of technology, not all hospitals have all types of diagnostic/treatment equipment, thus the client may need to be transferred to a regional medical center where the condition can be diagnosed and/or treated. Some hospitals specialize in treating certain conditions or age groups. Examples of these specialized hospitals are children's hospitals, which provide care to infants and children through the teen years; psychiatric hospitals, which provide care for people with mental illnesses; and government hospitals, which provide care for military personnel and their dependents. Figure 1.1 identifies the departments that may be found in a hospital.

The **long-term care facility** is also an inpatient health care facility. Such a facility may be referred to as a nursing home or an extended care facility. It may be privately owned, but more commonly belongs to a corporation that specializes in owning and operating this type of health care facility. The long-term care facility provides care for those who are unable to care for themselves. The clients at a long-term care facility are usually referred to as **residents**. It is commonly assumed that all residents are elderly, but some, who cannot care for themselves, are young people who have been involved in accidents or have life-threatening illnesses. Other residents are severely mentally retarded or have severe physical limitations. Even though the facility is designed for long-term care, some residents stay only a short time, convalescing or being rehabilitated before returning to their places in the community. The range of services in long-term care facilities varies from simple care, providing only for basic activities of daily living, to complex care, including ventilator care, intravenous therapy, and extensive rehabilitation. Unlike the hospital, the long-term care facility does not have physicians and other professionals on site at all times. Most of the diagnostic and treatment services are contracted, meaning that providers of those services are called when there is a need for them, and they come to the facility only to provide the service. Most long-term care facilities make an effort to create a homelike atmosphere.

There are two ways in which a long-term care facility may be licensed to provide care. A facility that provides 24-hour room, board, personal care, and basic health and nursing care services under the daily supervision of a licensed nurse and the direction of a licensed physician is called an **intermediate care facility**. A facility that provides 24-hour room, board, skilled nursing care, and treatment under the supervision of a registered nurse and the direction of a licensed physician is called a **skilled nursing facility**. Skilled nursing care refers to rehabilitative care for those who have the potential to regain function. Some long-term care facilities may be licensed for both intermediate and skilled care.

Other facilities that may fall into the broad category of long-term care facility are **residential care facilities**, which provide room, board, basic personal care, and 24-hour protective oversight. Clients of residential care facilities usually do not require nursing services, but cannot live independently because of physical or mental limitations.

Individual communities offer a variety of health care related services. One of these services, **home health care**, has become an important industry. A home health care agency delivers care and services to people in their homes including nursing care; physical, speech, or occupational therapy; social work services; assistance with homemaking tasks; transportation services; laboratory services; and provision of medical equipment and supplies. Some home health agencies operate as a service of a hospital; others are independent, operating either for profit or not-for-profit. There are also public agencies that provide home health care, such as state and local health departments and departments of social services.

Other health services available in the community are physicians' services provided in their offices for health maintenance or diagnosis of acute conditions; outpatient clinics, where clients with either acute or chronic health conditions may be seen; community mental health centers, which reduce inpatient hospitalization of the mentally ill; hospices, which provide care for dying clients; and nutrition/senior centers, which provide socialization and nutrition to the elderly.

The Health Care Team

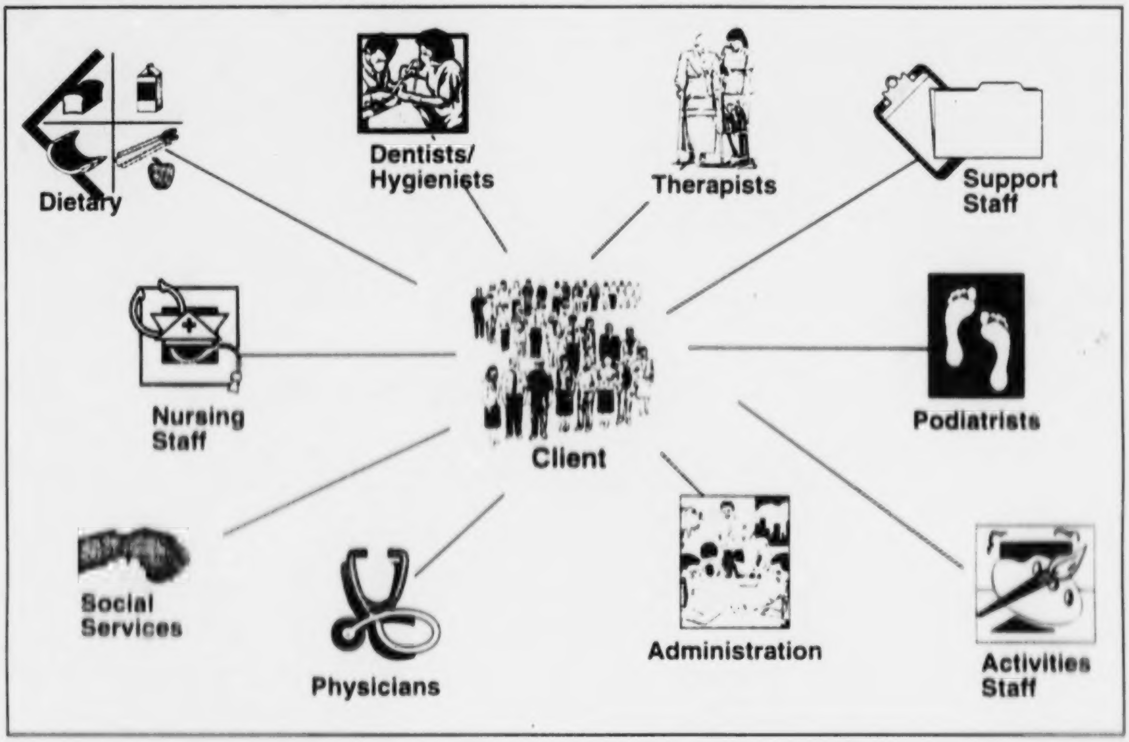
The client is the center of the health care team and the person around which all care is coordinated. See Figure 1.2. Each client has unique, individual needs that can be met by one or more members of the health care team. The members of the team must understand their roles and functions and be willing to cooperate with others so the client's needs can be met in the most efficient manner.

The **physician** makes the diagnosis and gives the orders for medication and treatment.

The **administrator** is responsible for all aspects of the operation of the health care facility in which care is being given. This might be a hospital, a long-term care facility, or a home health agency.

The nursing staff is composed of multiple members. The **registered nurse** (RN) plans, assigns, and evaluates nursing care. The RN is responsible for coordinating all care and for making sure the quality of care is acceptable. All nursing tasks are the responsibility of the RN; the RN may do them or delegate them to other members of the nursing staff. The RN will take and record physicians' telephone and verbal (in person) orders. Teaching the staff or the clients is also the RN's responsibility. To prepare for these responsibilities, a prospective RN must complete two to four years of training, depending on the type of nursing program attended. Upon completion of the nursing program, the candidate must pass a national computerized competency examination before he or she is eligible to practice.

Figure 1.2 - The Health Care Team



The **licensed practical nurse** (LPN) must practice under the direction of a registered nurse or a licensed physician. After completing a year of training and passing the national computerized competency examination, the LPN assists in planning, assigning and evaluating nursing care. The LPN is able to perform most treatments, including giving medications. The LPN may either give complete physical, psychological, and social care to a client or may assist others with that care, depending on the setting in which the health care is delivered. In long-term care, the LPN takes and records physicians' telephone and verbal orders. With training beyond the basic practical nursing program, the LPN may start intravenous fluid therapy.

The **certified medication technician** (CMT) is a role found specifically in long-term care. Those wishing to be CMTs must have successfully completed the *Medication Technician* course and met the requirements of the Division of Aging. There is also a final practicum examination that the CMT must pass prior to being certified. The duties of a CMT include preparing and administering selected medications, transcribing physicians' orders, observing and reporting effects of medications, and assisting with resident care. With additional training after the basic medication technician course, the CMT may administer insulin.

The **nurse assistant** provides for and assists with activities of daily living. The provision of bedside care is the nurse assistant's primary responsibility and includes such tasks as feeding, dressing/ undressing, bathing, measuring and recording vital signs, weighing and measuring height, bowel and bladder retraining, communication, maintaining a safe environment, and transferring and positioning. The nurse assistant must make accurate observations and know to whom these observations should be reported. The setting in which the nurse assistant works determines his or her responsibilities. Certification is required in long-term care, but some hospitals and home health agencies do not require nurse assistants to be certified. A nurse assistant who has passed the certifying exam is called a certified nurse assistant, or a CNA.

The **unit secretary** or unit clerk is responsible for the paperwork functions of the nursing unit. This position is usually only utilized in hospitals and some long-term care facilities. The unit secretary functions as the receptionist for the nursing unit, answering the telephone and the clients' call lights, and directing visitors to the unit. The unit secretary transcribes the physicians' orders and is responsible for ordering the medications and treatments prescribed by physicians. Other responsibilities of the unit secretary are keeping the clients' charts in order, filing diagnostic reports with the proper charts, making sure forms utilized by the health care team are available, and tracking use of and ordering supplies.

Although the nursing staff has the most direct contact with the client, the health care team would not be complete without other members to assist in returning clients to their optimal functioning.

In hospitals and long-term care facilities there is a dietary department composed of one or more dieticians, dietary supervisors, and dietary staff. The dieticians may be housed in the facility or they may be consultants. The responsibilities of the dieticians include approving menus, evaluating the dietary intake of clients, and counseling clients with nutritional problems. The dietary supervisor manages the dietary department by ordering supplies and foods and supervising the dietary employees. The dietary staff prepares and serves food, washes dishes, and maintains appropriate sanitary standards in the dietary area. In home health, it is usually only the dietician who works with the client to evaluate nutritional status and provide dietary counseling. In long-term care, dieticians participate in residents' nutritional assessments.

Special therapists are needed by clients in all health care settings. The physical therapist plans and provides therapy that promotes rehabilitation and instructs staff in restorative nursing procedures. In long-term care, **restorative aides** work under the direction of a physical therapist to provide ambulation, transfer, and other mobility assistance to residents. An occupational therapist restores, maintains, or improves daily living skills, such as eating, grooming, hygiene, toileting, and dressing. A speech therapist identifies, assesses, and rehabilitates people with speech or language disorders, such as the inability to correctly pronounce words. The respiratory therapist (may also be called an inhalation therapist) evaluates respiratory status, administers special breathing treatments, and maintains and monitors special respiratory equipment.

The social services department is staffed by a social worker and/or designee. Generally, the responsibilities of the social worker are to review the rights and responsibilities of the client, provide counseling for social and emotional needs of the client and family, and provide discharge planning and follow-up. In long-term care, the social worker, or designee, may screen residents prior to admission to determine if the facility can meet the residents' needs. In both long-term and home health care, the social worker will also assist in finding community services;

for example, financial resources, transportation, nutrition, aids to daily living (wheelchairs, canes, etc.), and homemaking services.

There are many support services without which the direct care providers could not function. Such services as housekeeping, laundry, and diagnostic testing are essential to keep the facility functioning or clients independent in their own homes.

In long-term care facilities and in many extended care wings or skilled nursing facilities of hospitals, there is a special member of the health care team, the **activities director**. He or she is a member of the staff who specializes in activity planning and coordination. The person providing this service conducts group and individual activities so that each client's activity needs are met. Also, this person usually coordinates and supervises the volunteers, and schedules community-sponsored activities in the facility. Some facilities may employ recreational therapists, who have received extensive training in assessing and planning activity needs of clients.

In home health and long-term care, since the client may be homebound or restricted in physical activities, other health team members may need to make home visits or come to the nursing home. The dentist or dental hygienist examines, cleans, and evaluates the teeth. The podiatrist comes to give foot care and keep toenails trimmed.

Role of the Nurse Assistant

The nurse assistant works directly with the client to provide physical care and meet emotional needs. Since the nurse assistant is often the only caregiver to spend considerable time in meeting the client's needs, this role is very important on the health care team. Each health care facility will have a **job description** stating the activities and responsibilities of the nurse assistant. Although the basic role will be the same in any setting, the nurse assistant's responsibilities will vary from one facility to another. Figure 1.3 shows the basic tasks assigned to most nurse assistants.

The role of the nurse assistant in acute care may carry more responsibilities than are listed in Figure 1.3. Many hospitals train their own nurse assistants to fulfill multiple roles. If there are not enough unit secretaries, the nurse assistant may be asked to do the tasks assigned to that role for a shift. Other roles the nurse assistant may be asked to fill are those of housekeeper, dietary staff, or patient transporter. The nurse assistant may be asked to take on specific roles or a combination of several roles. Some hospitals will train nurse assistants to do more advanced procedures, such as catheterizations and sterile dressing changes. Some of the titles by which the nurse assistant may be known in acute care are nurse's aide, nurse assistant,

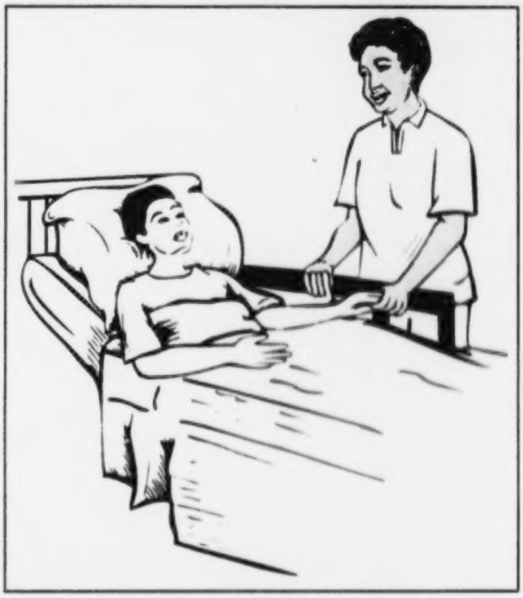
Figure 1.3 - Nurse Assistant Tasks

- Report client information and observations to the supervisor as directed.
- Assist clients with personal care.
- Make beds.
- Keep the clients' environment clean, orderly, and safe.
- Assist with phases of rehabilitation, such as ambulation, turning, and positioning.
- Provide care to the dying client.
- Measure vital signs.
- Assist with nutrition.
- Perform simple procedures, such as dressing changes, and measuring intake and output.
- Care for equipment.
- Give basic emergency care.

health care assistant, ward attendant, orderly, patient care technician, or unlicensed assistive personnel. The nurse assistant in acute care will usually work under the direction of a registered nurse.

The role of the nurse assistant in long-term care is well defined by the regulations for long-term care in the state of Missouri. The tasks are taught as part of a 175-hour course entitled *Nurse Assistant in a Long-Term Care Facility*. The responsibilities include observation and reporting, charting, communication, understanding the elderly, safety, food service, personal care, elimination, restorative nursing, and special procedures (see Figure 1.4). Anyone employed as a nurse assistant in long-term care in Missouri must complete the course within a specific time frame depending on the type of facility where employed. Prior to completing the course and passing the written and practicum examinations, the worker is called a nurse assistant or nurse's aide. After passing the examinations, the worker is a certified nurse assistant (CNA). The nurse assistant in long-term care is usually assigned tasks based on the plan of care developed by the registered nurse. Each shift may be supervised by a registered nurse or a licensed practical nurse.

Figure 1.4 - Nurse Assistant at Bedside



The nurse assistant working in home health is usually referred to as a **home health aide**. The primary responsibility of the home health aide is to provide basic nursing care, specifically those tasks related to the activities of daily living, such as bathing, feeding, dressing, ambulation, and transfers. In some instances, the home health aide may be required to do light housekeeping and prepare simple meals. Home health aides will need to be certain they know the tasks expected of them in each home. Clients needing this type of nursing are "on their own turf" and may be resistant to strangers entering the home. The home health aide must be confident, flexible, and well organized in order to gain the client's trust and meet his or her needs. Usually there is no licensed nurse on the premises although one is always available by phone. Therefore, the home health aide must be able to work without constant supervision and have sharp observation skills to be able to pass on pertinent information to the supervising nurse. Besides the client, there is usually at least one other caregiver in the home, a spouse, a parent, or a child, with whom the home health aide has to establish a relationship. This primary caregiver will also have needs and fears for which the home health aide will need to provide support and answer questions. Ingenuity may be required, as supplies that are common in an inpatient setting are not available in the home. The home health aide works under the direction of a registered nurse or another health professional (e.g., a physical therapist) who is responsible for guiding the care of the client.

Figure 1.5 - Sources of Payment

TYPE OF PAYMENT	DESCRIPTION
Private Health Insurance	• Paid for by the individual
Employer Provided Health Insurance	• Worker has availability to purchase insurance through payroll deduction or as a benefit of employment • Worker is limited to options provided by the employer and must meet the eligibility for enrollment in the health insurance plan
Special Insurances: *• Worker's Compensation* *• Auto Insurance*	• Provided for workers injured on the job • Provided when injuries are sustained in an automobile accident
Health Maintenance Organizations	• Prepayment for health care • Person pays a fee per month and health maintenance is provided by the organization • Organization uses most cost-efficient methods of treatment & eliminates unnecessary care by using case managers
Medicare	• Federally funded health insurance for those 65 years and older, the disabled, and those on dialysis • Certain services are covered, others are not
Medicaid	• State funded health care for low income people • Eligibility varies from state to state • Basic health care services provided

Types of Health Care Insurance

All health services must be paid for by someone. Payment for services comes from many sources. See Figure 1.5. Payments may vary from state to state. The nurse assistant is usually not responsible for obtaining payment sources for the client, but familiarity with the different types of payment may make it easier for the nurse assistant to understand the fears of the client or why some services may be unavailable.

Some clients may have more than one type of insurance, such as Medicare and private insurance. Coverage for benefits may be very specific and may depend on certain conditions being met by the client. If clients have questions regarding insurance coverage, there should be a person within the health care agency who can answer them.

Impact of Regulatory Agencies on the Health Care Industry

Health care agencies must conform to certain standards imposed by the federal or state governments. To ensure that standards are being met, agencies are inspected and surveyed on a regular basis. If an agency meets minimum standards set by the state, it is called a **licensed facility**. Not all states have this regulatory mechanism. If an agency wishes to be eligible for Medicare and Medicaid reimbursements, it must meet the minimum standards set forth for those payment sources by the federal government. The state inspects the agency, and if the agency meets the requirements, it is a **certified facility**. The agency can also choose to be **accredited** by a national professional organization. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires that standards be met to improve patient outcomes in acute care facilities. Accreditation is a voluntary process. Most agencies also pay a bond to an insurance company to enable them to pay damages if a client sues due to an employee's action. These regulatory agencies ensure that the public is protected. Employees of an accredited agency can also be assured that the agency is operating within minimum guidelines.

Current Trends in the Health Care Industry

Trends in the health care industry can be categorized into three areas: changes in health care delivery, changes in client expectations, and changes in the population.

In some respects, this is an exciting time to be in health care because expanding technology increases diagnostic and treatment capabilities. What was unheard of twenty years ago is now commonplace. Because of this increased knowledge, clients are more likely to recognize poor nursing and/or health care treatment techniques, thus following proper procedures is crucial for a health care provider. Someone has to pay, however, for the advances in technology, so the cost of the equipment and its operation and maintenance get passed on to the consumer, who is the client with health care needs. Thus, increased health care costs go hand in hand with advances in technology. Health care has moved to "drive-through medicine" with very short inpatient stays as one of the ways to contain health care costs. This change has caused a boom in the home health care industry, but it has not always been beneficial for the client. Unfortunately, in an effort to contain health care costs, many health care agencies are now profit- rather than patient-driven. The whole health care industry has moved from small, stand-alone agencies (physicians' offices and hospitals) to corporate systems, in which many facilities merge to contain costs. In another effort at cost containment, insurance companies introduced managed care, where all care provided must meet the conditions of the insurer.

Clients are no longer passive recipients of health care. Easy access to information has resulted in a better educated public that knows its health care options. Clients are consumers of health care, and they now have more of a consumer mentality in regard to care. If clients do not like the health care they receive, they may challenge their health care providers. People in our society, as evidenced by the growing number of malpractice cases and the skyrocketing costs for malpractice insurance, are increasingly more likely to blame others than to take personal responsibility when things go wrong. Thus, if the health care procedure or treatment does not go as the client would wish, the client often blames the health care worker or the system.

There are far greater numbers of elderly people now than at any time in history, and those numbers will continue to rise. The baby boomers, born after World War II, compose the greatest part of the current population. As they age and live longer than previous generations due to advances in health care, they will compose the largest aged population the United States has ever had. Thus, there will be a need for workers who understand the elderly and for resources to care for the aged around the beginning of the twenty-first century. The move from treatment of illness to health promotion (preventive health care) will also help to retard the effects of many of the diseases common today, such as heart disease and cancer. People will begin to live longer and be more productive as they take responsibility for their own health and well-being.

Community Resources

The social services department within a health care facility is the first source to utilize to obtain resources for a client. Most social services departments maintain a list of community services that can be accessed by clients with specific needs. The social services department of the local government may also have printed material available on a variety of topics with resources listed. Local offices on aging have information for the elderly as well as a listing of senior centers in the community. Churches and synagogues offer support to persons of all ages. Such services may consist of home visits, telephone contact for the homebound, transportation, homemaking assistance, and simple home maintenance. Adult day care and delivered meals may aid the caregiver of a homebound person. If the caregiver has unmet emotional needs, there are support groups available for help in coping with many diseases and chronic disorders. For a nurse assistant providing care to clients of all ages and with all types of needs, the easiest way to learn about resources in the community is to explore, either in person, by telephone, or via the Internet. Many places have literature available identifying the services provided. Collected information can be placed in a file for future reference.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 1: The Health Care Industry

Activity Sheet

1. List five types of health care settings:

   a. ____________________

   b. ____________________

   c. ____________________

   d. ____________________

   e. ____________________

2. List the two ways in which a long-term care facility may be licensed to provide care.

   a. ____________________

   b. ____________________

3. Who is at the center of the health care team? ____________________

4. List and describe five members of the health care team.

   a. ____________________

   b. ____________________

   c. ____________________

   d. ____________________

   e. ____________________

5. Why is it important to know the job description for the nurse assistant position in which you are employed? ____________________

   ____

6. List the basic tasks of the nurse assistant.

a. ______________________________

b. ______________________________

c. ______________________________

d. ______________________________

e. ______________________________

f. ______________________________

g. ______________________________

h. ______________________________

i. ______________________________

k. ______________________________

7. What is the role of the nurse assistant in:

a. acute care ______________________________

____

b. long-term care ______________________________

____

c. home health care ______________________________

____

8. Identify two trends in the health care industry.

a. ______________________________

b. ______________________________

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9. List the six types of insurance coverage.

   a. ____________ d. ____________

   b. ____________ e. ____________

   c. ____________ f. ____________

10. What impact do regulatory agencies have on the health care industry?

    ____

    ____

11. List three community resources to assist clients.

    a. ____________

    b. ____________

    c. ____________

Clinical/Laboratory Activities

1. Visit a hospital, long-term care facility, or home health agency and write out short answers to the following questions:

   a. Name the members of the health care team who work in the health care facility you visited.

   ____

   ____

   ____

   b. What is the role of the nurse assistant in the facility?

   ____

   ____

   c. Which regulatory agencies govern the facility?

   ____

   ____

2. Interview a health care team member that you are acquainted with in your community and have him or her identify two current trends in the health care industry.

   a. ____

   b. ____

3. Ask your parents or the persons responsible for your health care what type of insurance coverage you have and what benefits are provided.

   ____

   ____

4. Interview the public health nurse or someone at the health department to find out what community resources are available in your community that would assist a client in some aspect of health care.

   ____

   ____

Lesson 2:
Being an Efficient, Effective Practitioner

Objectives:

A. List steps in the problem-solving process.

B. Organize workload and prioritize tasks.

Key Terms:

- Problem-solving process

Nurse assistants are faced with multiple demands on their time and expertise. Caring for eight to ten clients in an inpatient facility or driving to two or three homes to care for clients every day requires a well-organized individual who is able to solve problems. Clients are much more comfortable with a health care worker who is efficient, confident, and knowledgeable.

The Problem-Solving Process

Particularly in home health care, the nurse assistant must function fairly independently. There will be many situations that are not emergencies but still require the nurse assistant to make a decision regarding client care. The supervisor will expect nurse assistants to think for themselves within the boundaries of the knowledge they possess. The six-step **problem-solving process** can help in making these decisions.

STEP ONE: Identify the problem. What is wrong? What does the client need? The nurse assistant may need to ask several questions to get to the root of the problem. A client who says, "I can't eat," may mean any one of several things; for example, does she have no appetite? Can he not fix his own meals? Can she not swallow? Does his religion require fasting at certain times, such as on holidays? The problem must be identified for the problem-solving process to be effective.

STEP TWO: Determine the cause of the problem. Who or what is responsible for the problem? What factors contribute to the problem? The problem may have several causes, which may influence the solutions to be identified.

STEP THREE: List all the possible solutions to the problem. Some of the possibilities may sound unreasonable, but it is best to list them all before they are forgotten. The most seemingly far-fetched idea may lead to the most workable solution. Clients and their goals must be considered when identifying solutions.

STEP FOUR: Identify the advantages and disadvantages of each solution. In this step, the best options should become apparent.

STEP FIVE: Choose the best solution and try it. No two situations are alike, so what seems best in one case may not be the best in another.

STEP SIX: Evaluate the results of the solution. Did it work? Is the problem resolved? Is the problem only partially solved? Does something else need to be done? If the problem isn't resolved, repeat the process. Were errors made at one of the steps in the process? Was the problem and its cause(s) correctly identified? Were all possible solutions considered? Was the best solution chosen? Perhaps one of the other solutions originally listed might work.

The problem-solving process is used repeatedly throughout the work day to assist clients with their needs. The more often the process is used, the more quickly the nurse assistant will be able to do it. The nurse assistant should mentally review the process for minor day-to-day problems, but if a major problem arises with a client or family, the process can be done in writing with all concerned parties contributing.

Organizing and Prioritizing

The first tip on organizing and prioritizing is to arrive at work on time! Allow for preparation time before giving care to patients. In an acute or long-term care environment, a nurse assistant who rushes in at the last minute will miss out on valuable information about which clients can be left alone for a while and which need immediate attention. Pay attention during the supervisor's report to be sure that all pertinent information has been received. Write down assignments and keep notes during the day about additional tasks to be done and information to be passed on. Make a quick round of assigned clients to confirm what has been reported and consider how to proceed. The plan of care is also a valuable resource for information about procedures that need to be done and guidelines for care. Some people can organize mentally; others will have to make a written list of items to be accomplished and prioritize them on paper.

Keeping supplies and equipment well organized allows for more efficient client care. For example, if the nursing unit has only one sphygmomanometer, it might be better to take all the clients' blood pressures in one round rather than returning to the nursing station between working with individual clients.

Some procedures require two caregivers. In those cases, the nurse assistant will have to organize his or her time around the availability of another person. There are always small tasks that can be done until a coworker is available to assist with a client.

In home health, driving time must be considered when organizing the work load. Also, a client's home is a much less controlled situation than an inpatient setting, thus the way the work has been previously organized may not be feasible upon arrival.

The home health aide knows, prior to visiting a client's home, the tasks that must be accomplished. The home health aid is given the assignment by the supervisor and told the purpose of the visit. The tasks most frequently assigned home health aides are bathing the client, assisting the client with other personal hygiene procedures, assisting the client with ambulation, and bed changing. While a logical plan may seem readily apparent to the aide, flexibility is needed as the client may have a very different plan. Working with clients to meet their needs while also completing all necessary tasks, home health aides may, at first, find organizing and prioritizing tasks more challenging than they would be in an institutional setting.

Organizing and prioritizing are continuous processes. Unexpected responsibilities and tasks arise during every working day. The efficient nurse assistant is constantly identifying what has been accomplished and what is yet to be done. It may be necessary to rearrange priorities after each task is done to ensure that clients' basic needs are being met.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

After you have completed the activity sheets, you may take the written evaluation for this unit. A score of at least 80 percent indicates you may proceed to the next unit.

Lesson 2: Being an Efficient, Effective Practitioner

Activity Sheet

1. List the steps in the problem-solving process

a. ________________________________

b. ________________________________

c. ________________________________

d. ________________________________

e. ________________________________

f. ________________________________

2. Identify a problem which you have encountered in your life and work through the six-step problem-solving process to find a solution.

a. ________________________________

b. ________________________________

c. ________________________________

d. ________________________________

e. ________________________________

f. ________________________________

3. Describe methods you use to help organize your time and prioritize tasks you must accomplish in a day.

____

____

____

____

4. The following is a list of tasks and procedures which must be accomplished prior to breakfast. Prioritize them from one to five with one being the task you would do first.

   - Mr. Jones needs help getting out of bed.
   - Mr. Smiley would like to call his daughter.
   - Mrs. Alvarez has to use the bedpan.
   - Mrs. Givens cannot find her pink sweater that she always wears to breakfast.
   - Mr. Spitz has been incontinent of feces and his bed is soiled.

   a.

   b.

   c.

   d.

   e.

Clinical/Laboratory Activities

1. There are probably no absolutely right or absolutely wrong ways to prioritize the activities in number four on your activity sheet. Prioritizing often depends on the circumstances. Work in groups of four to five with your classmates to give your reasons for prioritizing as you did. After your discussion, would you prioritize the tasks differently? If so, how and why?

2. Share your tips for organizing and prioritizing work with the other members of your class. Record other tips you have learned from them.

Unit Checklist

Student Name ________________________________ Overall Unit Rating ________

Activity Sheet: The Health Care Industry Rating ________

Comments: ____

____

____

Activity Sheet: Being an Efficient, Effective Practitioner Rating ________

Comments: ____

____

____

Written Unit Evaluation Score ________

Additional Comments: ____

____

____

Teacher Signature ________________________________ Date ____________

Student Signature ________________________________ Date ____________

Unit II

Employment

To find employment in health care one doesn't simply fill out an application and answer questions in an interview. Certain processes must be followed.

Once employed, the nurse assistant must be aware of and prepared for the stresses of working in health care. This unit discusses how to recognize stress and includes stress-management techniques.

Unit Lessons

Becoming Employed in Health Care

Taking Care of Yourself

Lesson 1:
Becoming Employed in Health Care

Objectives:

A. Describe the job search process.

B. Discuss employee rights.

C. Identify requests that are beyond the nurse assistant's training.

D. Compare the lines of authority in acute, long-term, and home health care settings.

Key Terms:

- Resume
- Reference
- Application
- Interview
- Employee rights
- Lines of authority
- Organizational chart
- Centralized system
- Decentralized system
- Functional nursing
- Team nursing
- Primary nursing
- Case management

The success of a job search is determined by how well the employment processes are completed and the attitude with which an applicant approaches the process and the people involved. The employer is seeking someone who has the skills to do the job efficiently and who can be a loyal team player. Some employers may attempt to hire a person to do a job for which they do not possess the necessary skills. Potential employees must know the limitations of their practice and when to decline positions or tasks that are beyond the scope of their training. As mentioned in Unit I, Lesson 1, each health care agency should have a job description of any open position that describes the tasks to be performed.

Employment Processes

The first step in the job search is reviewing personal assets and liabilities, personal likes and dislikes, and career goals. Once these are accomplished, the applicant should prepare a resume and identify references.

A **resume** is a typewritten summary of information about educational and work history. The resume should be prepared prior to the interview and it can be sent with the letter of interest (discussed in Figure 1.1). The information presented in the resume includes the following:

- personal identification (name, address, phone number)
- work experience
- education, including any certifications
- honors and awards
- membership in professional organizations

The resume should be typed neatly on standard size white or off-white paper with correct spelling and grammar. One to two pages is the preferred length. Multiple copies should be made so they can be sent or given to any job source.

Ask at least three people to serve as **references**. A person serving as a reference is not a relative of the applicant, but is someone who knows him or her well and can speak positively about the applicant's personal characteristics and work history. Persons who could serve as

Figure 1.1 - Ways of Finding Jobs

Personal Contact with Facilities	• Visit the facility's personnel or human resources department. • Check the facility's bulletin board for posted job openings. It may be located somewhere in the vicinity of the personnel department. If no bulletin board exists, ask the receptionist or secretary about openings.
Letter of Interest	• A letter of interest can be sent to the personnel department. The letter should identify the type of job sought and the applicant's qualifications.
Telephone Contact	• The personnel department may be contacted by phone to obtain job availability information.
Advertisements	• Advertisements and listings may be on the internet. • Local or regional newspapers carry information about jobs. • The Sunday employment section of large newspapers contains the most help wanted ads, and there is usually a section for health care.
Friends/Colleagues	• Friends who are working in health care may know of job openings in the facilities in which they work. Some facilities will ask their employees to spread the word about job availability to save on advertising.
Job Fairs/ Open Houses	• Schools and health care facilities hold job fairs and open houses to show interested persons what the facility is like and what job opportunities are available.

references are instructors, former supervisors, ministers, physicians, or health care workers. No one should be listed as a reference without his or her permission. Some may want to provide a letter of recommendation that can be attached to the resume or carried to the interview.

After the applicant has determined career goals, completed a resume, and has identified references, he or she needs to find out what jobs are available. There are several ways to locate job openings; they are outlined in Figure 1.1.

Some jobs will not be appropriate due to training requirements, and some may be incompatible with the seeker's preferences and goals. Some jobs will allow no chance for advancement; others will offer the employee the possibility of promotion.

An **application** is a form to be filled out when requesting a job after personal or telephone contact is made with a facility. The application should be filled out neatly, legibly, and completely, with no spelling or grammatical errors. No answer spaces should be left blank on the application; any question that is not applicable should be indicated with "n/a" in the answer space.

The next step is the **interview**, an appointment to speak with a potential employer. It should be noted that not all applicants are interviewed; therefore, doing a good job with the resume and application are extremely important. To set up an appointment, talk to someone in

Figure 1.2 - Interview Dos and Don'ts

DOS	DON'TS
• Do plan what you will wear to present a neat and clean, professional appearance. • Do dress conservatively with minimal jewelry and make-up and an attractive, conservative hairstyle. • Do arrive on time. • Do stand until asked to sit. • Do watch body language as it tells more than the verbal language. • Do be prepared by knowing what is on the resume. (Take an extra copy, so if you forget you can refer to it.) • Do share information in as clear and concise a manner as possible. • Do make eye contact. • Do sit quietly and avoid using distracting mannerisms (e.g., playing with your hair, kicking your leg back and forth).	• Don't chew gum. • Don't smoke. • Don't accept coffee or another beverage if you cannot handle it and the interview without being uncomfortable. • Don't call the interviewer by his or her first name unless invited to do so. • Don't take someone else (mother, child, friend) with you. • Don't ignore questions or make-up answers if you don't know. State you don't know or would like to think about the answer. • Don't talk in a monotone. • Don't use slang or profanity. • Don't argue with or contradict the interviewer.

the personnel department. The interviewer will ask questions to determine if the applicant is a good candidate for the job. Just as important as the answers the applicant offers is the first impression he or she makes. That impression is made within the first five minutes of the interview. Other workers in the personnel department may be giving feedback to the interviewer about their impressions of the applicant, so it is always wise to be pleasant to the receptionist, secretary, and others in the facility. Figure 1.2 lists some "dos and don'ts" for the interview.

There may be more than one interview. Some facilities use a trained interviewer in the personnel department for the first interview and then invite acceptable candidates to interview with the supervisor of the open position. The original interview may be nothing more than a brief screening of all applicants.

In the interview the applicant should also ask questions about the facility and the job. A tour of the facility may be offered. Figure 1.3 lists some of the information that should be obtained from the facility during the interview. Figure 1.4 provides some tips on how to respond to interviewer's questions.

Prior to employment, a copy of the following items may be requested. The applicant should take them to the interview so that copies can be made if requested.

- driver's license
- social security card or green card
- high school transcript
- competency sheets from nurse assistant training
- certificate of completion of training program

In addition, a criminal background check will be done prior to employment and

Figure 1.3 - Information Obtained During Interview

- Work hours
- Salary
- Job description
- Fringe benefits available:
  - Insurance:
    - health, dental, vision, life
    - provided by the facility or through payroll deduction
    - available for worker and/or family
  - Vacation
  - Sick leave
  - Pension
  - Tax deferred savings plan
- Uniform/dress requirements
- Upward mobility in the organization
- Educational opportunities
- Health/wellness programs

the employer may also require the applicant to take a drug screening test.

The applicant should keep notes about the interviews and the health care facilities. If several facilities offer employment, notes can be reviewed so that the best choice is made. After the interview, a note of thanks written to the interviewer makes a positive impression.

If more than one facility makes an offer, the applicant should quickly decide which position to accept, then he or she should call to accept the offer and send a letter of thanks to the other facility. If a prospective employer hasn't been in touch by the date agreed upon for notification, it is acceptable to call and ask the status of the job. Any time a position is not offered, the applicant should evaluate his or her performance during the interview for areas needing improvement before scheduling another interview. Some of the reasons people are rejected for positions might be:

- they are unprepared.
- they have distracting mannerisms or speech.
- their attitude is negative.
- their appearance is unprofessional or hygiene is unacceptable.
- they do not have the skills required for the job.
- another applicant has stronger skills.

The offer of a position may be conditional upon the passing of a drug screening and a physical. Even if a complete physical is not required, the facility may ask for immunization records and administer a tuberculosis (TB) screening test. New employees may also be asked to read a policy handbook and sign a statement of compliance with facility policies, such as attendance and conduct, and general rules and regulations.

If the nurse assistant is not certified at the time of employment, certification training

Figure 1.4 Tips on Responding to Interviewer's Questions

- Be honest.
- Be flexible about hours and job responsibilities (as long as they are within the scope of practice for the job).
- Make liabilities into assets by indicating a willingness to work on those areas that are weaknesses. Ex: "I have only worked with a maximum of three clients, but I am willing to practice my priority-setting skills and would enjoy the challenge."
- Be positive about achievements without bragging.
- Be positive about former employers and/or schools and instructors even though the experience may not have been pleasant or comfortable.

is required in long-term care and may be required in other health care settings. Continued employment in the facility is based on successful completion of certification training within a specified length of time.

Employee Rights

Employers have the right to expect employees to be competent and loyal. But what do employees have the right to expect from employers? Some may feel that because employees are being paid to perform a service, they have no rights. This is not true, and workers must understand their **employee rights**, knowledge and/or privileges that a worker can expect from his or her employer. Health care workers have the right to review their job descriptions and to understand the roles employers expect them to fulfill. Job descriptions will identify the tasks for which workers are responsible and may also describe job limitations. Workers have the right to expect clear, written policies regarding benefits the facility provides and performance standards the facility has set. Workers have the right to discuss working conditions with supervisors or regulatory agencies without fear of termination of employment (but such a discussion should not interfere with accomplishing tasks).

Some facilities have unions to which workers may belong. Unions have a union steward present in the facility or available to workers with whom they may communicate at any time. Workers have the right to be free of sexual harassment and discrimination of any kind. The Civil Liberties Union and the Equal Employment Opportunity Council may be contacted to handle discrimination.

Because safety is such an important issue in health care, workers have the right to expect the environment to be as free of hazards as is possible. Surveys and safety inspections should be available for employees to read at any time. If employees feel there is a breach of safety, or if they believe there is immediate physical danger to themselves or to clients, they have the right to request an inspection. Any citations made by the Occupational Safety and Health Administration (OSHA) should be posted on the premises of the facility. Signs should be posted regarding exposure to dangerous chemicals or radiation. Employees have the right to a record of their own exposure to toxic substances and the right to a medical examination if their health is affected by exposure to those substances.

If a client poses a safety threat to health care workers, they have the right to know what behavior the client exhibits. If any worker does not have the skill to deal with the behavior, he or she has the right to refuse the assignment or request the neccessary training.

Declining Requests Beyond the Scope of Training

Once employed, there will be times when work is hectic, with multiple tasks to be accomplished in a limited time by a limited number of workers. Supervisors or team leaders may feel pressured to ask workers to do tasks which are not part of their job responsibilities or for which they have not been trained. These are not simple requests like "Mrs. Jones has emptied her water glass all over the floor again. Would you please mop it up before someone falls?" In this case, while mopping up water is not in the nurse assistant's job description, recognizing and correcting safety hazards is. Attending to simple tasks that enhance the well-being of clients is also something that can be done at the request of the supervisor without overstepping the bounds of what the nurse assistant can and should do. These would be tasks such as delivering mail, watering plants, or cleaning equipment.

The tasks that the nurse assistant should question are those for which special training is required, such as sterile procedures or administering medications. If the supervisor asks a nurse assistant to do a task for which he or she feels unqualified, the nurse assistant should calmly explain that he or she has not had the proper training. If the supervisor insists, the nurse assistant should repeat that explanation. The nurse assistant should remain calm and pleasant and might offer to complete another task for the supervisor (if there is one within the nurse assistant's capability) to relieve some of the supervisor's workload. If the supervisor continues to insist or threatens to have the nurse assistant fired for insubordination, the nurse assistant has the right to ask to speak to the supervisor's boss. As soon as possible, the nurse assistant should write down as many of the details of the incident as he or she can remember.

In some instances, the agency will provide specialized training for such tasks as drawing blood, inserting catheters, or providing extensive wound care. If the agency provides the training, nurse assistants should make sure that the agency will stand behind them and guarantee they have the skills with which to do the task. Until the training is complete, no nurse assistant should attempt to do those procedures without supervision.

Lines of Authority

To ensure that communication flows smoothly from one level to another, there are lines of authority in all health care agencies. **Lines of authority**, which are the decision-making levels wihtin a health care setting, work two ways. First, the line of authority enables supervisors to know the health care workers for whom they are responsible. The second function is to show workers the person to whom they report and if there are problems with a direct supervisor (as in the example in the previous section). Lines of authority are shown on the health care agency's **organizational chart** which is a diagram or listing of the employee positions and their level of authority.

Health care delivery systems are organized in two ways, centralized and decentralized. In a **centralized system**, the lines of authority are direct from top to bottom. Decision making begins at the top of the organization and is directed downward. In a **decentralized system**, responsibility for power and authority has been delegated to lower levels in the organization.

Within a health care facility, nursing can also be organized into different care delivery systems. In **functional nursing**, care is divided by tasks among the members of the team. Each member performs a specific function (for example, bathing) for all of the clients assigned to the team. **Team nursing** is more common. One member of the team, most often a registered nurse, takes responsibility for organizing and coordinating care of the clients. Under this team leader, the registered nurses, licensed practical nurses, and nurse assistants share the responsibility of caring for the clients assigned to their team. The less skilled members of the team may take the clients requiring less complex care, and those with more training and experience would care for those requiring more complicated care. **Primary nursing** uses an all registered nurse staff. When a client is admitted, a primary nurse is assigned to that client. The nurse is then responsible for all care 24 hours a day for as long as the client remains in the health care facility. Since no one can work all the time, the primary nurse is assisted by associate nurses who care for the client in the primary nurse's absence from the unit. **Case management** is the newest way to organize nursing care. The registered nurse coordinates the care provided by all members of the health care team, of which the nursing staff is only a part.

In *acute care*, any of the four nursing care delivery systems may be used. In *long-term care*, functional and team nursing are the most common. In *home health care*, the case management system is the most common. Although the nurse is the case manager, the home health aide may be doing some specialized tasks, such as restorative nursing (range of motion exercises, ambulation, feeding techniques). When that is the situation, the home health aide may be working directly with the therapist while reporting back to the case manager.

To remain employed in health care, a nurse assistant must know his or her job description, perform assigned tasks effectively, and follow the lines of authority in whichever nursing care delivery system the assistant is employed.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 1: Becoming Employed in Health Care

Activity Sheet

1. Describe the job search process.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

   e. ______________________________

   f. ______________________________

2. What are some of the ways that can be used to find a job?

   ____

   ____

   ____

3. What are the five basic items that are included on a resume?

   a. ______________

   b. ______________

   c. ______________

   d. ______________

   e. ______________

4. Name three persons who would be appropriate to ask to serve as references.

   a. ______________

   b. ______________

   c. ______________

5. Identify five things to do that contribute to a successful interview.

a. ______________________________

b. ______________________________

c. ______________________________

d. ______________________________

e. ______________________________

6. Name five objects an applicant should take to an interview.

a. ______________ d. ______________

b. ______________ e. ______________

c. ______________

7. Name five employee rights.

a. ______________________________

b. ______________________________

c. ______________________________

d. ______________________________

e. ______________________________

8. When is it appropriate to decline a supervisor's request?

____

____

9. What are the two purposes for lines of authority?

a. ______________________________

b. ______________________________

10. Describe a centralized and a decentralized organization.

    a. centralized: ______________________________

    b. decentralized: ______________________________

11. Describe the four ways nursing can be organized.

    a. functional nursing: ______________________________

    b. team nursing: ______________________________

    c. primary nursing: ______________________________

    d. case management: ______________________________

Clinical/Laboratory Activities

1. Visit the personnel department of a health care facility and obtain an application for employment.

    a. Fill out the application as if you were seeking a job as a nurse assistant.

    b. Compare your application to those of other members of your class who have obtained applications from other health care facilities.

    c. What information do the applications have in common?

    ____

    ____

    ____

    d. What information is specific to only one application, and why might that health care facility require that information?

    ____

    ____

    ____

2. Role-play the interview process with a classmate, being first the interviewer and then the interviewee. What questions were hard to answer?

3. Obtain a copy of the local newspaper and list the jobs available for a nurse assistant.

4. Your supervisor asks you to adjust the setting on the monitor for the feeding pump. You have never worked with a feeding pump before. Write your response to the supervisor.

Lesson 2:
Taking Care of Yourself

Objectives:

A. Define stress.

B. Compare external, internal, and interpersonal stressors.

C. Identify the phases of stress.

D. Identify the signs of stress on the body.

E. Compare appropriate and inappropriate stress-management techniques.

F. Implement techniques to manage stress.

Key Terms:

- Stress
- Stressor
- External stressor
- Internal stressor
- Interpersonal stressor
- General adaptation syndrome
- Alarm phase
- Resistance phase
- Exhaustion

All of us are familiar with stress at home, on the job, and even during recreational leisure time. Health care work is stressful. The comfort, care, and even the continuation of another's life is in the health care worker's hands. People who are ill are not always pleasant to deal with either. The nurse assistant will need to know how to recognize and manage stress not only personally, but in clients and, perhaps, even in other health care team members.

What is Stress?

Stress is the body's response to the demands of life. It is unavoidable and can even be desirable. The stress of an upcoming exam may cause a student to study harder, which is a desirable response. Stress is a real physiological process, not a psychological phenomenon. The way the body responds to demands is unique to each individual. No two people will respond in exactly the same way, though there are some similarities. Stress can be caused by any demand, whether it's simple or complex. The demands on the body are called **stressors** and can be either positive or negative. Examples of positive stressors would be getting married, buying a new home, and meeting new people. Examples of negative stressors would be divorcing, losing a job, and being in debt. Stressors are of three types. **External stressors** are those that come from the environment, such as heat or noise. **Internal stressors** are those that come from within a person, such as pressuring oneself to excel academically by thinking that only an "A" on a test is acceptable. **Interpersonal stressors** are those that come from demands made by other people, such as when one spouse expects the other to do all the housework, even when they both hold jobs outside the home. Whether the stressor is positive or negative and external, internal, or interpersonal, the body must adapt to the demand. This is called the **general adaptation syndrome** and consists of the general physiological processes the body goes through to maintain life.

Phases of Stress

During the general adaptation syndrome, the person goes through three phases of stress in attempting to meet the demand. In the **alarm phase**, the body gears up to

Figure 2.1 - Symptoms of Stress

PHYSICAL	EMOTIONAL	COGNITIVE	SOCIAL	SPIRITUAL
• nail-biting • tense muscles • restlessness • insomnia • problems with appetite, either loss or excess • stomachache • headache • problems with the bowel: diarrhea, constipation • frequent urination • dry mouth • sweaty palms and clammy skin • hyperventilation	• complaining • crying • anger • irritability • apathy • frustration • mood swings • depression	• confused • forgetful • daydreams • inability to problem-solve	• sullen • withdrawn • defensive • blames others • inability to relax	• purposeless • lack of sense of self-worth • thinks life is meaningless • lets go of values

fight or flee the demand. The person's heart rate, respiratory rate, blood pressure, and metabolism increase. There is more sugar released into the bloodstream, and the pupils dilate. The body perspires. All this occurs to help the body work faster, see better, and have enough energy to meet any demand. The body can endure this extreme physiological response for only a short period of time and adapts by going into the **resistance phase**. The body tries to balance the need to work faster with some conservation measures to help it keep going to handle the demand. It is during this phase that the actual symptoms of stress begin to occur. The last phase is **exhaustion**. When the warning signals of stress symptoms are not heeded, the body shows signs of illness. If the person does not show signs of trying to control the stress, the body takes control and "makes" the person sick so they are removed from the demand.

Signs of Stress

As mentioned above, the signs of stress occur in the second phase as a warning to the body to remove itself from the stressor. Each person has a unique warning system, but in general, the symptoms can be classified as physical, emotional, cognitive, social, and spiritual. Figure 2.1 shows some of the symptoms of stress.

The individual may display one or more of the symptoms of stress in any combination from any or all of the categories.

The ultimate effect of stress on the body as seen in the exhaustion phase is illness. Examples of stress-related illnesses are ulcers, cardiovascular disease, and hypertension. Unrelieved stress has also been proven to delay healing and to cause greater susceptibility to infections.

Figure 2.2 - Stress Management Techniques

- Follow healthy living practices: eat a balanced diet, get the proper amount of rest, and exercise regularly.
- Practice relaxation techniques.
- Allow yourself to express emotions in appropriate ways.
- Resolve conflicts.
- Indulge yourself on occasion.
- Don't be afraid to say "no."
- Use humor or go see a funny movie.
- Don't "borrow" problems from the future; take one day at a time.
- Allow yourself to daydream on breaks.
- Use support systems to get emotional, social, and physical needs met.
- Talk about your feelings with someone you trust.
- Allow yourself to play.
- Relabel a stressor or a problem as a challenge or a learning experience to readjust your outlook.
- Whisper positive encouragement to yourself.

Managing Stress

The first step to managing stress is to identify the stressors. It may be possible to remove some stressors; some may be altered; and others may be unchangeable and thus require an "attitude adjustment." Once stressors are identified, a plan can be established for removal or management. The final step in management is to act on the plan. The problem-solving process discussed in Unit I, Lesson 2, will aid in establishing a management plan. Some stress-management techniques are listed in Figure 2.2.

Unfortunately, people frequently use inappropriate methods to relieve stress. Drinking alcohol; smoking; using over-the-counter, or illegal drugs; ignoring the stressor; and walking away from the situation only cause the body to react again. Some of the actions listed above are physically damaging to the body, which is an internal stressor in itself.

The nurse assistant will find that health care is physically demanding (an external stressor), emotionally demanding (an internal stressor), and requires teamwork (an interpersonal stressor). The nurse assistant must then be careful to recognize signs of stress in him- or herself and in others, and implement appropriate techniques to manage that stress before signs of illness are present. If stress is not relieved by any of the techniques suggested in this lesson, the nurse assistant should seek the help of a health care provider or counselor. Acknowledging that help is needed and seeking such help is a positive step in relieving stress.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

After you have completed the activity sheets, you may take the written evaluation for this unit. A score of at least 80 percent indicates you may proceed to the next unit.

Lesson 2: Taking Care of Yourself

Activity Sheet

1. What is stress?
2. Give examples of the following:
   a. external stressors
   b. internal stressors
   c. interpersonal stressors
   d. positive stressors
   e. negative stressors
3. What happens in each of the phases of stress?
   a. alarm phase
   b. resistance phase
   c. exhaustion phase

4. Give three examples of signs of stress in each of the categories of symptoms.

   a. physical

   ____

   ____

   ____

   b. emotional

   ____

   ____

   ____

   c. cognitive

   ____

   ____

   ____

   d. social

   ____

   ____

   ____

   e. spiritual

   ____

   ____

   ____

5. Identify five actions that help to manage stress.

   a. ____

   b. ____

   c. ____

   d. ____

   e. ____

6. Describe three inappropriate methods of handling stress.

   a. ____

   b. ____

   c. ____

Clinical/Laboratory Activities

1. Identify three external stressors in your life.

   a. ____________________

   b. ____________________

   c. ____________________

2. Identify three internal stressors in your life.

   a. ____________________

   b. ____________________

   c. ____________________

3. Identify three interpersonal stressors in your life.

   a. ____________________

   b. ____________________

   c. ____________________

4. Get together with a group of three other classmates and discuss each of your stressors. Are there similarities among the stressors you have identified? What are they?

   ____

   ____

   ____

5. Working in your groups, identify any symptoms of stress that you have. Perhaps you will not be able to identify your own symptoms, but the other members of the group have seen some signs in you that they can identify. Describe how you each respond to stress by identifying at least one symptom in each of the categories of symptoms of stress.

   ____

   ____

   ____

6. Working in your groups, identify any other ways you have of managing stress. Are these appropriate or inappropriate methods of management?

Unit Checklist

Student Name ______________________ Overall Unit Rating ________

Activity Sheet: Becoming Employed in Health Care Rating ________

Comments: ______________________

Activity Sheet: Taking Care of Yourself Rating ________

Comments: ______________________

Written Unit Evaluation Score ________

Additional Comments: ______________________

Teacher Signature ______________________ Date ________

Student Signature ______________________ Date ________

Unit III

Interpersonal Relationships and Communication Skills

In health care, a group of people work as a team to meet clients' needs. How people in any group interact is called group dynamics. How well or how poorly team members work together affects customer, or client, satisfaction.

Clients are unique individuals. Their personalities and behaviors reflect their various cultural backgrounds. Some behave in ways that may seem strange to the nurse assistant but are acceptable in their own cultures. Behavior is based on emotional or physical needs. The nurse assistant will work with many different people and must look at each person as an individual with unique needs.

One key to working in groups and with diverse populations is communication. The nurse assistant will be responsible for giving information verbally, in writing, and by computer, to many people. Team members must know what, when, and how to communicate for the team to function smoothly. Effective communication skills are also important for establishing good interpersonal relationships with clients.

Unit Lessons

The Team Approach to Quality Health Care

The Client as a Unique Individual

Communication Skills

Lesson 1:
The Team Approach to Quality Health Care

Objectives:

A. Define a group, interpersonal relationships and group dynamics.

B. Describe the phases of a group.

C. Discuss the roles of members of a group.

D. Participate as a team member.

E. Discuss viewing clients and their families as customers.

F. Identify characteristics of quality health care providers.

G. Provide quality health care.

Key Terms:

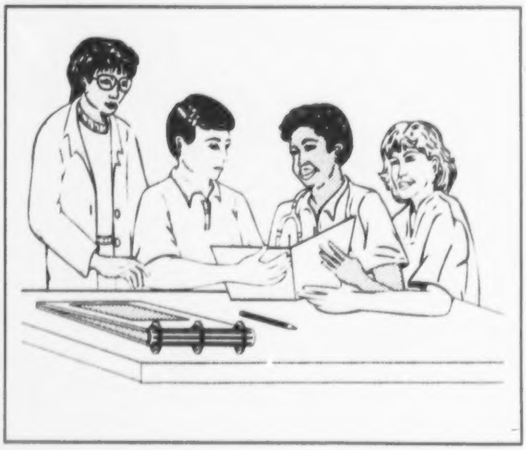
- Group
- Interpersonal relationship
- Therapeutic relationship
- Group dynamics
- Initiation phase
- Working phase
- Termination phase
- Leader
- Task function roles
- Maintenance function roles
- Self-oriented roles
- Customer

Increasingly, health care employers are looking at how well the employee is a team player in determining continued employment. No single job role in health care functions independently. The better health care employees work together, the more efficient the delivery of care and the faster clients' needs are met. The faster clients' needs are met, the more cost effective delivering care will be for the facility. Employers need team players who give quality care and value the client as a customer.

Groups, Interpersonal Relationships and Group Dynamics

A **group** is a collection of two or more people. In health care, many groups form and reform every working day. Some are simple; for example, the client and the health care worker are a team at any given moment. Some are large and complex, such as the whole health care team that establishes both short- and long-term client care goals. See Figure 1.1. All groups exist because the people in them are dependent on each other in some way, working together toward a common goal. For example, the group consisting of client and nurse assistant occurs because the client needs basic nursing care, and the nurse assistant can provide it.

Figure 1.1 - The Health Care Team as a Group



An **interpersonal relationship** is the relationship that develops between people in a group. The relationship is based on the interaction between the people. Interaction is how one person responds to another person's behavior. Only if both people feel good about the interaction will a positive interpersonal relationship develop. The group will work more effectively when positive interpersonal relationships exist.

The relationship between a health care worker and a client is a special interpersonal relationship. It can be called a **therapeutic relationship**, in which the client must be helped and must feel better due to the interaction. The nurse assistant must establish therapeutic relationships and meet clients' needs or clients will not feel satisfied with the care they receive.

To create and maintain positive interpersonal relationships, health care workers must first know themselves. How do they react to confrontations? What "pushes their buttons?" What makes them feel angry, sad, frustrated, and happy? Once workers understand the reasons for their feelings, they can put themselves in the client's place and understand his or her feelings and actions. Empathy is being able to understand how another person feels.

Group dynamics is the way the members of the group interact. A group of three health care workers who have worked together for several years interacts differently than a group made up of three newly hired people. Similarly, the nurse assistant-client group that has developed good communication skills will have better interaction (group dynamics) than one lacking these skills.

Phases of a Group

Although groups must form very quickly in health care, every group goes through certain phases as it establishes and completes work. In the **initiation phase**, group members determine relationships. They identify goals and purposes of the group, and each member of the group takes on a role. In this phase, the nurse assistant-client group begins with the introduction of both members. For example, the nurse assistant says, "Hello Mr. Jones, I'm Sandy and I'll be taking care of you today." The nurse assistant then establishes the immediate goal by saying, "It is time for breakfast, so I need to help you go to the bathroom and wash."

The **working phase** involves problem-solving and the achievement of the goals of the group. How can the nurse assistant accomplish the group goal of getting a client who has paralysis on the left side out of bed and ready to eat breakfast? The nurse assistant must figure out how to transfer the client from the bed to a chair. Would a high, firm chair be better than a low, soft one? Would a wheelchair be better than a stationary chair? The client and the nurse assistant work together to accomplish the task using the client care skills the nurse assistant has learned and the strength and ability of the client.

The **termination phase** occurs after the task is completed. Team members should feel a sense of accomplishment. This phase involves summarizing activities and disbanding. Again, using the example above, the task is completed when the client is out of bed and ready to eat breakfast. The nurse assistant may say something such as, "You really are learning to stand and pivot. I didn't have to help you nearly as much this morning. Enjoy your breakfast. I'll be back later to check on you." The nurse assistant has ended the group at this point. This group might reconvene later and would go through the same three phases again, although the initiation phase might be shorter.

Group members interact differently in each of the three phases. Those who have worked together frequently will not have to communicate the goals and purposes of the group, establish their roles, or establish group norms when they regroup for new or changing clients' needs. Norms are the standards of behavior that are developed and adopted by a group during the initiation phase. Thus, in established groups, the initiation phase will not require a great deal of communication. Group members already know how each of the other members solves problems, so rather than discussing problems, they may act. Many groups in health care (such as the health care team) are ongoing. These groups have the goal of providing quality care for the clients at the health care facility. The nurse assistant-client group ends when the client no longer needs health care services.

Roles of Members of a Group

Each member of the group plays a role. Roles are not necessarily established by job titles. Each member of the group can play any of the roles anytime and may play more than one role in any given group encounter. The **leader** is the person responsible for guiding a group and ensuring that its task is completed. Some leaders take complete control; others are more democratic and allow group members to help in the decision making. Groups may have a formal leader, a person who is designated to be the leader. Some groups have an informal leader, a person who does not have the title but to whom the other group members turn for guidance. Group members fulfill two categories of roles that aid the group to accomplish its goals: task function roles and maintenance function roles. **Task function roles** are those that relate to what the group must accomplish. **Maintenance function roles** are those that help the group work together, promoting unity and keeping the group encouraged and on task. There are also **self-oriented roles**, in which group members seek to meet their own needs rather than those of the group. Figure 1.2 defines the roles that maintain the group.

Each member of the health care team fulfills one or more of these roles every day. Quality health care cannot be delivered to clients without fulfilling the task and maintenance function roles. When members take on self-oriented roles, teams do not operate efficiently, and clients do not receive the expected services.

Clients and Families as Customers

Clients and their families are important members of the group called the health care team. They may at first fulfill the roles of self-orientation since they are in the health care system to have their needs met. The work of the team will be to meet those needs so that each client moves toward task or maintenance function roles. Only when the client fulfills one or more of those roles can the team begin aiding the client to return to health. The goal of the client is to get the best quality health care at the most affordable price. When the client thinks this goal is not met or perceives it not to have been met, he or she will go elsewhere to purchase services. The client views himself or herself as a **customer**, someone who is purchasing a service and has a right to expect that service to be of high quality. If the client/customer does not receive satisfaction, he or she may expect compensation. This is one reason for the rise in lawsuits

Figure 1.2. - Roles of Group Members

TASK FUNCTION ROLES

- Initiator - thinks of new ideas; keeps group moving toward the goal or goals
- Information Seeker - tries to obtain information the group needs; sees where information that the group has is lacking
- Evaluator - evaluates the group's progress and checks to see if all group members agree
- Coordinator - puts ideas together; builds on others' ideas
- Procedural Technician - does routine tasks
- Recorder - serves as secretary; keeps notes and communicates needs in writing

MAINTENANCE FUNCTION ROLES

- Encourager - supports others; accepts group members as they are
- Harmonizer - mediates; reconciles disagreements
- Compromiser - attempts to bring opposing members together in a solution acceptable to all
- Standard Setter - keeps the group aware of norms
- Gatekeeper - keeps track of time; makes sure all participate and are allowed to communicate
- Tension Reducer - uses humor effectively; makes sure the group takes needed breaks

SELF-ORIENTED ROLES

- Aggressor - attacks other members of the group or the group as a whole; takes credit for group; belittles others
- Blocker - has negative attitude; stubbornly opposes everything; brings up old issues that the group has previously settled
- Recognition Seeker - calls attention to self; boasts
- Playboy/girl - makes fun of important issues; displays lack of interest
- Dominator - very authoritative; interrupts; gives directions
- Help Seeker - seeks sympathy from the group; needs help with tasks; "poor me"

against health care workers. Health care facilities naturally wish to avoid the long and costly process of defending provided care. One way to avoid the cost is to hire workers who recognize that responding to clients' needs is very important.

Characteristics of Quality Health Care Providers

Quality health care is working as a team, establishing positive interpersonal relationships, and keeping the client as the focus around which all the team revolves. What are the characteristics of the person who provides quality health care? Health care workers who follow the golden rule -- treat others as they would like to be treated -- are the most successful. People who have a positive attitude or outlook are more pleasant to be around. They may even influence others to see things or situations in a better frame of mind. All behavior is learned, but some characteristics seem to come naturally to a person, such as shyness or saying funny

Figure 1.3 - Characteristics of Quality Health Care Providers

- Dependable
- Knows limits of the job role
- Accurate
- Able to follow directions
- Conserves supplies
- Flexible
- Efficient
- Trustworthy
- Cooperative
- Courteous
- Even-tempered
- Keeps personal problems and private life to self
- Actively listens to others

things; other behaviors must be practiced until they feel natural. Listed in Figure 1.3 are some characteristics of health care workers who provide quality client care.

Every member of the team will not possess all of these characteristics. When members are willing to learn, these traits can become a part of the nature of every worker and lead the team to provide high quality health care.

Test Your Knowledge: Complete the following activity sheet and clinical/ laboratory activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 1: The Team Approach to Quality Health Care

Activity Sheet

1. Define a group. ______________________________

2. What is an interpersonal relationship? ______________________________

3. What is the difference between an interpersonal relationship and a therapeutic relationship?

4. Define group dynamics. ______________________________

5. Describe what happens in each phase of a group's working together.
   a. Initiation phase ______________________________
   b. Working phase ______________________________
   c. Termination phase ______________________________

6. What does a group leader do? ______________________________

7. What is the difference between a formal leader and an informal leader?

8. Describe three task function roles in a group.

   a. ______________________________

   b. ______________________________

   c. ______________________________

9. Describe three maintenance function roles in a group.

   a. ______________________________

   b. ______________________________

   c. ______________________________

10. Describe three self-oriented roles in a group.

   a. ______________________________

   b. ______________________________

   c. ______________________________

11. Why should clients be viewed as customers?

   ____

   ____

   ____

12. Identify six characteristics that a provider of quality health care should possess.

   a. ______________

   b. ______________

   c. ______________

   d. ______________

   e. ______________

   f. ______________

Clinical/Laboratory Activity Sheet

1. Name three groups to which you belong and describe your role in each of these groups.

   a. ______________________________

   ____

   b. ______________________________

   ____

   c. ______________________________

   ____

2. Observe an interaction between two of your classmates. Describe how each acts and what each says. How did the second person respond to the actions or statements of the first?

   ____

   ____

   ____

3. Role-play with a classmate interactions between a client and a nurse assistant. Pretend you are the client and your partner is the nurse assistant. The nurse assistant is meeting the client for the first time and will be giving them a bedbath and making his or her bed.

   a. What are the things your partner said that made you feel good?

   ____

   ____

   b. Was there anything your partner said that made you feel uncomfortable or hurt your feelings?

   ____

   ____

4. Ask to observe a group. If your program participates in a vocational student organization, observe an officer's meeting. You may also observe a church or school group.

    a. Identify the phase(s) the group was functioning in and how you determined this?

    ____

    ____

    b. Who was the leader and was the leader domineering or democratic?

    ____

    ____

    c. Could you identify an informal leader? Explain why or why not.

    ____

    ____

    d. What roles were being played by various members of the group?

    ____

    ____

    e. What roles helped the group to accomplish its purpose, and what roles blocked the work of the group?

    ____

    ____

5. Interview the patient advocate, patient representative, or public relations specialist at one of your local health care facilities. Ask them to identify what the client expects as a customer of their services.

    ____

    ____

    ____

6. Interview a health care provider in your community. What characteristics did they state are necessary for a health care worker to provide high quality health care?

____

____

____

____

7. Divide into groups of five or six students. Discuss characteristics other than those already mentioned in the text that your interviewees identified as important in the health care worker.

____

____

____

Lesson 2:
The Client as a Unique Individual

Objectives:

A. Discuss diversity of clients.

B. Exhibit sensitivity to the diversity of others.

C. Describe defense mechanisms clients use to cope with their emotions.

D. Discuss challenging behaviors in clients and how to manage them.

E. Exhibit tolerance to challenging clients and/or families.

F. Describe clients' and/or families' reaction to loss.

G. Discuss techniques to use when working with a depressed client.

H. Exhibit sensitivity to clients' and/or families' pain and loss.

Key Terms:

- Diversity
- Prejudice
- Disability
- Culture
- Stereotype
- Religious diversity
- Economic diversity
- Emotion
- Defense mechanisms
- Anxiety
- Overdependence
- Demanding client
- Agitation
- Depression

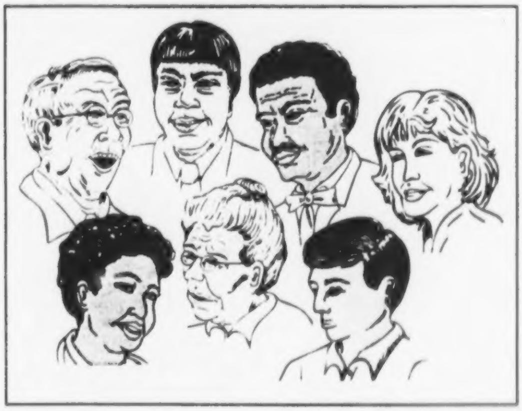
Look around. Are any two people alike? Even identical twins usually have very different personalities. Would it be boring if everyone looked, acted, and spoke alike? Being able to work with many different kinds of people is what makes health care so exciting. People are different in many ways and the health care worker must understand the differences in order to be successful.

Diversity of Clients

Diversity is the condition of being different. Nurse assistants are privileged to work with a variety of clients during their careers. Learning about different ways of "doing" and different ways of "being" is one of the interesting aspects of nursing. As trust develops with the nurse assistant, clients may want to share their views, values, and beliefs about religion, family, politics, gender issues, occupations, and social norms. The nurse assistant's own understanding of people can be enhanced by a willingness to accept diversity. The word **prejudice** may arise when discussing different types of people. A prejudice is an attitude, opinion, or feeling about someone or something that is based upon preconceived ideas or supposed characteristics. Nurse assistants, like all people, may be blinded by prejudices. To be effective health care providers, they must be willing to open their minds and learn what it is that makes each client unique. See Figure 2.1.

One way that clients differ is in age. The *Health Care Assistant Core* curriculum contains additional information regarding human life stages. The physical, mental, and social changes that occur in each of the life stages are presented and may be reviewed whenever necessary. The client's stage of life will influence his or her needs.

Figure 2.1 - Diversity of Individuals



A **disability** is a mental, physical, or social condition that makes a person incapable of functioning independently. People with disabilities usually recognize that they have special needs. The nurse assistant must support clients with disabilities, recognizing their unique needs, and encouraging them to reach as high a level of independence as possible.

The term diversity probably brings to mind culture. **Culture** is the set of values, beliefs, attitudes, and social behaviors that a group of people share and pass down from one generation to the next. The values and beliefs of a culture include such things as views about proper attire; proper table manners; appropriate health care; and attitudes toward gender, age, work, recreation, and people of other cultures. Language is also part of a person's culture. A **stereotype** is an assumption that all persons from a particular culture or background will act in a certain way. Even within cultures, people are unique. The nurse assistant must learn about clients' cultures to understand their behavior and communication patterns, and to establish a therapeutic relationship with them.

Understanding a client's culture is imperative for the home health aide because the client may have specific behavioral expectations in their home. Trust and acceptance will be difficult to obtain if the home health aide offends the client by not understanding his or her culture. The home health aide may need to ask if it is acceptable to do certain things, such as wearing shoes in the house. The aide must not assume the client shares the same cultural beliefs. It is better to ask if the client has any behavioral preferences than to make a mistake that may upset the client or primary caregiver. Always treat the client with respect and as an equal partner in completion of nursing care tasks. See Figure 2.2.

In America, we have **religious diversity,** or many different religions, and everyone has the freedom to practice the religion of their choice. Culture can influence religion. Religious practices may impact a client's health care. A client's religion may require him or her to eat specific diets or to fast. Some clients keep symbols nearby, such as the rosary or the cross. Religious customs

Figure 2.2 Working with Clients from Other Cultures

- Learn about cultures by asking questions and reading.
- Be nonjudgmental about clients' customs. There is no "right" or "wrong" culture. Each culture has customs that individuals, both inside or outside the culture, may like or dislike.
- Know your own prejudices. Everyone has them. Knowing what yours are can help you to control your behavior when confronted with a situation or person that triggers a prejudice.
- Share what you learn about a culture with the health care team if it is pertinent to the client's care.

may forbid certain medications or medical procedures. Clients may wish to speak to their religious leaders, such as a minister, priest, or rabbi, and may need time alone with them to speak about spiritual needs. For those clients who are deeply religious, the spiritual leader should be a part of the health care team. The nurse assistant should be sensitive to the spiritual needs of clients and respect their religious beliefs and practices. Having their spiritual needs met may comfort clients.

Economic diversity, or a wide range of income levels in the population, is another aspect of American life. Very poor clients may have care paid for by the government and very rich clients may pay for all medical services. The nurse assistant should care for all clients in the same manner regardless of their income level. When doing home health duties, the home environment may reflect each client's income and spending habits. The nurse assistant must be nonjudgmental and only seek to make changes if something in the environment negatively influences the health of the individual or is a safety hazard.

Defense Mechanisms

Entering the health care system can evoke a wide range of emotions in clients. An **emotion** is a feeling that has both psychological and physical aspects. Love, anger, and fear are emotions. Most people control their emotions and let them work for them in a healthy way; however, clients may feel a loss of control over their situation and become fearful. When people feel threatened, they begin to use behaviors that they feel are protective. These behaviors, called **defense mechanisms**, are specific techniques that combat a feeling of discomfort or a threat. Everyone uses defense mechanisms to deal with difficult situations. Using defense mechanisms only becomes a problem when a person uses them continually to block reality and fails to resolve the threatening situation. The following table (Figure 2.3) lists several mechanisms that may be used by clients.

The nurse assistant should recognize clients who use defense mechanisms for a short time as a way to cope. The nurse assistant should help clients work through their fear by encouraging them to talk and by respecting their feelings.

Managing Challenging Behavior

Anxiety is an emotional state characterized by a feeling of apprehension or unease. Everyone experiences anxiety at some time. While unpleasant, anxiety is normal and helps us face unknown experiences with heightened awareness. The anxiety felt the first day on a new job will help the nurse assistant be more alert and better able to remember new information. It becomes a problem when the sense of apprehension does not go away. A client may have a long period of anxiety if the client receives a large amount of information, undergoes many procedures, and must relate to several health care providers. The sense of anxiety may not be relieved until the client has a clear picture of what is wrong with them and understands the advantages and disadvantages of treatment options. To relieve clients' anxiety, the nurse assistant must be reassuring and supportive. Clients need as much information as possible about procedures. The nurse assistant should reinforce any teaching given to the client by the registered nurse, physician, or other health care personnel. (Client teaching is discussed further in Lesson 3.) Clients must also have as much control as possible over their daily activities. The

Figure 2.3 Defense Mechanisms

DEFENSE MECHANISM	DEFINITION	EXAMPLE
Denial	• blocking out any truth that may be painful	"The doctor's wrong. That wasn't really a mass on the x-ray."
Rationalization	• using excuses to explain something	"I didn't take the pills correctly before the test and that's why it looked like a mass on the x-ray."
Projection	• blaming someone or something else	"The doctor is out to make money. That's why I have to have surgery."
Displacement	• taking anger or frustration out on someone other than the one who caused the anger or frustration in the first place	The client is afraid to take out his or her anger on the physician, so says to the adult child who is visiting, "Quit yelling! You'd think I was old and senile the way you talk to me. If you can't treat me respectably then you can just go home."
Suppression	• refusing to acknowledge feelings	The client knows he has throat cancer and fears his wife will leave him if he can't talk normally. The client consciously refuses to talk about his diagnosis to anyone and will not tell his wife.
Fantasy	• daydreaming to avoid reality	The client, who has paralysis from the waist down from a car accident, dreams of dancing at the senior prom.

nurse assistant may have to remind clients that feeling anxious is normal.

Overdependence, an extreme reliance on health care personnel, may occur when clients feel they cannot cope with the current situation. Clients regress, or return to childish ways, to get their needs met. As children we felt secure and happy when our parents or caregivers helped us. The adult who becomes overdependent wants to experience those same feelings. The nurse assistant will need to encourage an overdependent client to do as much as possible for himself or herself and provide positive feedback when the person accomplishes even a minor task.

The **demanding client** attempts to exert control over the situation by "bossing" everyone, asking for help repeatedly, and requesting priority status for receiving care. To a nurse assistant, this type of behavior can be frustrating and cause the nurse assistant to avoid the demanding client. Avoiding this kind of client reinforces his or her feeling of being out of control and may make the behavior worse. The nurse assistant should look at the factors that are causing the behavior and attempt to give the client control whenever possible. Control can be given in simple ways, such as letting the client choose the time at which to ambulate in the hall. The nurse assistant can gain the client's trust by always doing what he or she has promised. For example, the nurse assistant may have to say, "I have other clients who need me at this time. I will be back to check on you in twenty minutes." When the nurse assistant does come back to check as promised, the client feels reassured. Being consistent in the daily routine or manner in which care is given reassures the client and builds trust.

Agitation is inappropriate verbal or motor activity by a person and may include such behavior as pacing, cursing, screaming, biting, or hitting. It may be due to physical, mental, or emotional causes. The nurse assistant must stay calm; using a raised voice or quick movements will only increase the client's agitation. If the nurse assistant fears for his or her personal safety, he or she should solicit help from the supervisor on how to manage the behavior. Restraining the client usually leads to greater aggression and agitation. Try setting limits on the behavior by telling the client what is unacceptable. Saying, "I do not appreciate the language you are using. I am going to leave the room for five minutes so you can get yourself under control. While I am gone, you may curse all you wish. When I return, you may certainly speak loudly if that helps you, but I would appreciate not being cursed." To relieve the frustration, the agitated client can use a substitute, such as hitting a pillow. Never argue with or confront the client. The environment should have no glass or sharp objects with which the client can damage the items in the environment, himself or herself, or others. The nurse assistant should avoid known triggers, either verbal or physical, that could cause the client to become agitated. If the nurse assistant is working in home health and the situation appears unsafe, he or she should leave the home and call the supervisor immediately.

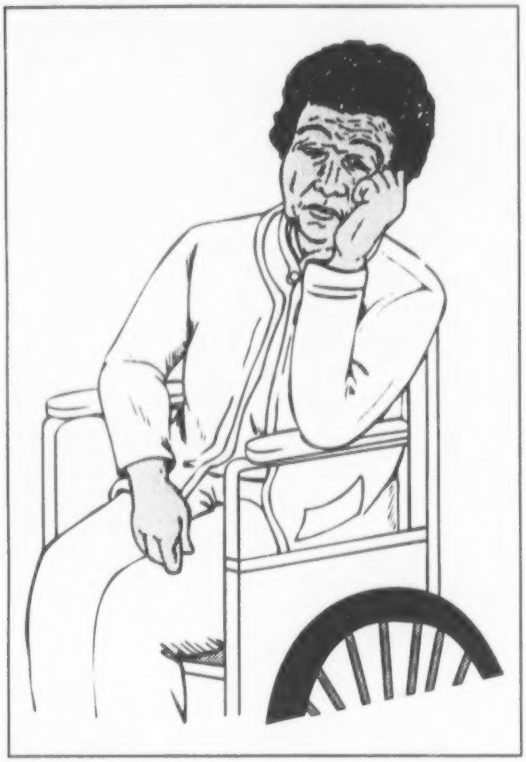
Nurse assistants can help clients with challenging behavior by recognizing that the behavior is not directed toward them personally. The behavior is the result of feelings and stresses which clients are attempting to manage. In each case, the nurse assistant should try to find out the cause of the behavior and try to relieve the client's stress. Without judging, the nurse assistant should listen if the client wants to talk and should try to empathize with how the client is feeling.

Loss

Clients entering the health care system have usually experienced loss--loss of health, loss of control over their situation, loss of ability to function. The loss may be temporary or permanent. The health care system may compound the loss by requiring a client to undergo surgery or other procedures that alter the physical state of the client's body. The client's family, or significant others, also experience loss. They may experience a loss of financial security if the client is the breadwinner in the family, or a loss of familiar roles in the family. The greatest loss is death.

Any loss causes a feeling of sadness. That sadness should pass with time. **Depression**, however, is a prolonged

Figure 2.4 - Recognizing Depression



feeling of sadness and hopelessness. Death and dying are presented in the *Health Care Assistant Core* curriculum and identifies depression as one of the five stages of dying as defined by Elisabeth Kubler-Ross. A person does not have to experience the death of a loved one to experience depression. Depression is a common reaction to illness, disability, or a loss of any kind. It can even be manifested in physical symptoms such as a poor appetite, difficulty sleeping, fatigue, headache, and generalized weakness. A depressed client may be apathetic; he or she may show no interest in their surroundings or what is done to or for him or her. If the depression is severe, the client may have suicidal thoughts and may even attempt suicide. See Figure 2.4.

In managing depression, the nurse assistant must be careful not to think that he or she can talk the client out of the depression. Resolving feelings of sadness takes time. The nurse assistant should actively listen to depressed clients and determine if they have support systems, such as family, to whom they can relate. Giving positive feedback for accomplished tasks can help improve a client's feeling of self-worth. Pity only validates his or her feelings of sadness. Simple activities can help keep the client occupied. If a client is too apathetic to complete activities of daily living, the nurse assistant may have to complete these tasks for the client. The nurse assistant should encourage the client to do them slowly, one small task at a time.

Depression is a very challenging condition. The nurse assistant may feel "down" also when caring for depressed clients and must be careful not to avoid clients displaying this behavior. Presenting a pleasant attitude and emphasizing the positive aspects of life will help clients to overcome depression.

Clients are unique individuals. Each possess different types of behavior, some pleasant and easy to deal with, some not so pleasant. The nurse assistant who shows sensitivity, empathy, and tolerance to clients and their behavior will be more successful at the job.

Test Your Knowledge: Complete the following activity sheet and clinical/laboratory activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 2: The Client as a Unique Individual

Activity Sheet

1. Describe the diversity that may be found among clients.

2. What is prejudice? What is the danger in having prejudices against clients?

3. List the defense mechanisms that clients may use to cope with emotions.

   a.

   b.

   c.

   d.

   e.

   f.

4. How can the following challenging behaviors be managed?

   a. Anxiety

   b. Overdependence

c. Demanding ____________________

d. Agitation ____________________

5. List six feelings or physical symptoms that a person with depression may experience.

a. ____________ d. ____________

b. ____________ e. ____________

c. ____________ f. ____________

6. Identify three techniques to use when working with the depressed client.

a. ____________________

b. ____________________

c. ____________________

Clinical/Laboratory Activities

1. Interview a person in your community from a different culture than your own. Have the person describe his or her cultural beliefs and behaviors.

2. Share with your classmates what you have learned about different cultures.

3. Identify a stressful situation you have encountered within the past six months. What behaviors did you use to help you cope? Are the behaviors like any of the defense mechanisms described in the lesson?

4. Role-play with a classmate the following scenes with one of you being first the client and then the nurse assistant. Identify what you would say or how you would act to help the client.

   a. The client is to have surgery in two days for extensive abdominal cancer. The client has never had surgery, but the client's sister died in surgery ten years ago because of a reaction to the anesthetic.

b. The client is in the hospital with a broken hip that has been surgically repaired. The client wants you to do everything for him or her although the doctor's orders state that the client is to be up in a chair and is to go to physical therapy twice a day.

c. Nothing you do is right for the client. He or she finds fault with everything you do, how you do it, what you look like, and what you say.

d. The client is screaming at you, "Go away and leave me alone. I'll hit you if you come any closer."

5. Identify a loss you have experienced in the last six months. How did it make you feel?

Lesson 3:
Communication Skills

Objectives:

A. Provide information about the client to the nurse in charge.

B. Communicate pertinent information at the shift change.

C. Chart observations and procedures.

D. Recognize and report incidents.

E. Complete incident reports.

F. Reinforce client teaching identified on the care plan.

G. Identify how computers are used in health care.

H. Maintain client confidentiality.

Key Terms:

- Objective observations
- Subjective observations
- Assessment
- Initial assessment
- Flow sheet
- Resident Assessment Instrument (RAI)
- Minimum Data Set (MDS)
- Documentation
- Incident
- Incident report
- Client teaching
- Confidentiality

Clear communication is vital in health care. The nurse assistant must communicate with many people to share information with clients and other health care team members. The *Health Care Assistant Core* curriculum covered basic information about communication, observation and reporting, and charting. This lesson will expand on that information.

Providing Information about the Client

There are basically five methods of client observation: seeing, hearing, smelling, touching, and taking vital signs. For nurse assistants, a sixth can be added--tasting. Certain circumstances, such as food preparation for a homebound client or nursing home resident who will not eat, may require a taste test to assess texture and seasoning of food. The food may then be improved to stimulate the client's appetite.

There are two types of observations. **Objective observations** are facts about a client that are gathered using one's senses. The following would be objective observations: "The client's face is very flushed; the client complains of pain in her right leg when she stands up." "The client's respirations have increased by 20 per minute since being taken at the beginning of the shift." "The client says there are bugs in his bed but none were found when the bed was searched." **Subjective observations** are one's opinions about a client. The following would be subjective observations: "The client shut the drawer of the bedside table very quickly and jumped when I entered the room. It almost seemed like he was trying to keep me from seeing something." "The client's husband was yelling at her and had his fists clenched. He looked ready to hit her. Maybe he has hit her before and that is what was causing the bruising on her arms." "I don't think the client is using the walker like he is supposed to because when I came yesterday, the walker was in the bedroom and he was out on the porch sitting in the chair." Objective observations are much more beneficial to the nurse in charge as these are the actual signs and symptoms observed in the client. The nurse assistant may voice opinions about what is happening with the client but should be sure to say to the nurse in charge that they are opinions.

Gathering information about a client is called **assessment**. Information gathered when a client enters the health care facility is called the **initial assessment**. Usually the nurse in charge is the person who gathers the information for the initial assessment. The nurse assistant can contribute any observations or information gathered during contact with the client. All health care workers report any observations about a client to the nurse in charge.

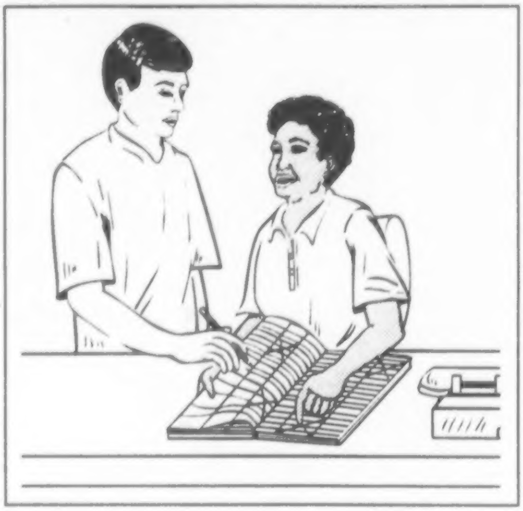
Information reported to the nurse in charge is necessary for the daily records that must be kept on the client. Each type of health care facility will have a different system of recording assessments. The acute care facility usually has an initial assessment sheet that must be completed on admission, a **flow sheet** on which daily information is checked or charted about the client, and some form of narrative charting for special problems. The long-term care facility has a **Resident Assessment Instrument** (**RAI**) that the whole health care team uses to provide information about each resident and to establish treatment goals. A component of the RAI is the **Minimum Data Set (MDS),** which is the document used by the nursing staff to compile assessment findings on each resident. In addition to the RAI and the MDS, the long-term-care facility may have other forms of documentation, such as a flow sheet and narrative charting. Home health usually has a combination checklist and narrative document on which to record assessment data. The home health aide may also be required to complete a time log of all activities and nursing care provided in the home.

When providing information about the client, the nurse assistant should know *who, what*, and *when*. Who should receive the information? The nurse assistant should know who is in charge of care for the client and should report any appropriate information to him or her. What should be reported? This question is a little more complex. The *Health Care Assistant Core* curriculum identified things to observe about clients and gave guidelines for reporting observations of status changes. Usually, the information provided to the nurse in charge should include all care and procedures completed for the client and any of those that were not completed. This would include any physical, mental, emotional, or social changes in the client; any complaints or questions the client may have; and any routine physiological functions, such as elimination, nutrition, and vital signs. When to report information will depend on its importance. Information to pass on immediately includes description of a client's injuries, such as falls, burns, cuts, bruises; change in a client's condition; and client complaints for which a medication can be administered, such as pain, nausea, or constipation. If the nurse assistant feels at all uneasy about when to report the information, he or she should report it immediately. Reporting information that could have waited until later is better than waiting and possibly jeopardizing a client's well-being. Knowing who, what, and when to report is a skill that takes time to develop. After gaining experience, the nurse assistant will become more proficient at determining what to report immediately and what can wait.

Change of Shift Report

In acute and long-term care, the health care team changes from shift to shift. The health care team that is leaving must transfer information needed to ensure that the care of clients is continuous to the team beginning its shift. Shortly before the shift ends, information about clients that was not immediate in nature must be reported to the nurse in charge (see Figure 3.1). This information would include those items identified in the prior section about what to report. The nurse in charge then compiles information about all the clients for whom the team is responsible and communicates this to the person in charge of the next shift. Unless information must be reported immediately, the home health aide may not verbally communicate with the nurse in charge when leaving the client. The home health aide should provide information, such as the client's likes and dislikes and the best way to complete procedures, when transferring responsibility for the client to someone else.

Figure 3.1 - Change of Shift Report



Charting

The purpose, responsibilities, and basic rules of charting were presented in the *Health Care Assistant Core* curriculum. **Documentation** is the recording or charting of information about the client in a permanent record. If no documentation exists, it is assumed that the client's care and/or treatments were not done. Each health care facility may have different ways of documenting information. The nurse assistant should know which forms to chart on, what type of charting to do (narrative, checklist, etc.), how often to chart and where to keep the documentation if it is outside the client's chart or record.

Recognizing and Reporting Incidents

Special communication forms are completed when an incident occurs. An **incident** is any act or situation that occurs in which a client is injured or has a potential for injury, or that has legal implications. Clients, family, visitors, or health care workers can all be involved in incidents. Examples of incidents would be falls, loss of property, or unsafe conditions. An **incident report** is a written account of what happened prior to, during, and after an incident. An incident should be reported immediately and an incident report completed before the facts of the situation are forgotten. Most health care facilities have a form on which the information is recorded. The form requests general information about the persons involved in the incident, a factual accounting of what happened, whether the person was injured, and if so, what treatment was given. Information also includes names of witnesses, their addresses and phone numbers. The supervisor can help the nurse assistant

Figure 3.2 - Considerations when Reinforcing Teaching or Giving Information

- Make sure the client is focused on the person giving the information.
- Use examples of how the information will help the client.
- Make sure you understand the information before trying to assist the client.
- Use language the client will understand. Health care workers sometimes use medical terminology that the client does not know.
- Give information slowly and in small segments.
- Remember that the client may need information repeated often before they understand it. Teaching takes patience.
- Allow time for teaching at a relaxed pace and for the client to ask questions.

with determining whether a situation requires an incident report and, if necessary, help the nurse assistant complete the incident report.

Client Teaching

Client teaching is giving information to clients that will enable them to manage their health care needs and to be as independent as possible in their own care. Everyone on the health care team communicates information to the client. Information may be simple instructions for helping the client get out of bed or complicated procedures, such as teaching the client how to draw up and administer injectable medications. Because each client learns differently, each has different teaching needs. Many factors influence how information should be communicated, including the client's age, life experiences, ability to learn, and motivation for learning. The supervisor, or sometimes the health care team as a whole, will establish the teaching plan for each client. The physician, the nurse, or other professional staff, such as a physical therapist, implements the teaching plan. The nurse assistant should be familiar with the teaching plan written in each client's plan of care. He or she should listen to instructions given by the staff. The nurse assistant's role is to reinforce or continue to emphasize the important points of the instruction. The supervisor may ask the nurse assistant to give immediate information to the client, such as the time of a doctor's appointment scheduled for the client. See Figure 3.2.

Computers in Health Care

In health care, as in most businesses, computers are commonly used as communication tools. Health care facilities use computers in various ways to communicate (see Figure 3.3). In some facilities, computers are used only in the business office for record keeping and financial accounting processes. Other facilities have hand-held computers that are used at the bedside so the health care worker can access and update all client information as

Figure 3.3 - Computers in Health Care

he or she helps the client. This "paperless" system may not have actual charts or forms on which to write; all client information is typed into a database. Usually, computers are used for the following tasks: maintaining client records; ordering tests and procedures; generating reports; inventorying and ordering supplies; and providing an information bank of details on policies, procedures, and medications. Nurse assistants will usually need basic computer skills to complete their job duties. If computers are used in the client care units, facilities will provide training programs to instruct workers on the use of their particular type of computer.

Confidentiality

Confidentiality means keeping client information private. Through a method that keeps the information most private, client information should reach only health care team members who need it to provide quality care. Health care facilities are very public places. Nurse assistants should not discuss clients and their care in public areas where any visitor or inappropriate personnel can hear. The nurse assistant may be taking care of friends, neighbors, or others who would like to have detailed information about their clients' conditions. Do not discuss health care work with family, friends, neighbors, or any concerned parties who might ask questions. Such questions are more likely to be asked in the less structured environment of home health care. A nurse assistant might care for several clients at different locations, and the clients may ask about one another. The easiest response to questions is a simple, "I cannot discuss my work." If a reporter from the newspaper, television, or radio approaches with questions, refer them to the supervisor. Accessing client information may be very easy in facilities that use computers. Nurse assistants should only access information on those clients for whom they must care. Simple human curiosity often prompts a person to find out what is wrong with a celebrity, a friend, a relative, or a very important person in the community. This is an invasion of that client's privacy. The client may start a lawsuit if he or she discovers that information was discussed or passed on to others.

Use the following questions--who? why? what? when? where? how?--to guide the communication process in health care. Who needs the information--the client, another member of the team, or a caregiver? Why is the information necessary? What information does the other person need? When is the best time to give the information? Where is the best place to give the information? How should the information be passed to another--verbally, in writing, electronically, or through a combination of methods? Using the questions will enable the nurse assistant to be a good communicator in the health care system.

Test Your Knowledge: Complete the following activity sheet and clinical/laboratory activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

After you have completed the activity sheets, you may take the written evaluation for this unit. A score of at least 80 percent indicates you may continue to the next unit.

Lesson 3: Communication Skills

Activity Sheet

1. List three objective observations you might make about a client.

   a. ______________________________

   b. ______________________________

   c. ______________________________

2. List three subjective observations you might make about a client.

   a. ______________________________

   b. ______________________________

   c. ______________________________

3. What is an initial assessment?

   ____

4. What documents are used to record data in the following health care settings?

   a. acute care ______________________________

   ____

   b. long-term care ______________________________

   ____

   c. home health care ______________________________

   ____

5. Answer the following questions in regard to providing information about the client.

   a. Who should receive information? ______________________________

   ____

b. What information should be reported? ______________________

c. When should information be reported? ______________________

6. What reporting happens at the shift change?

7. What assumption is made if no documentation exists?

8. What is an incident? What information about an incident must be reported?

9. List three considerations when reinforcing teaching or giving information to a client.

a. ______________________

b. ______________________

c. ______________________

10. What are three ways that computers are used to communicate health care information?

    a. ______________________________

    b. ______________________________

    c. ______________________________

11. What is the nurse assistant's responsibility regarding confidentiality of information?

    ____

    ____

    ____

    ____

Clinical/Laboratory Activities

1. Work with a classmate to complete the following exercise.

    a. List some objective observations about your partner.

    ____

    ____

    ____

    b. List some subjective observations about your partner. Check with your partner to see if these opinions were correct or incorrect.

    ____

    ____

    ____

2. Inspect the charting documents provided by the instructor. Identify whether the charting is a narrative, a flow-sheet, or another form of documentation.

    ____

    ____

3. The following is information about the client you have taken care of during the day. Mrs. McGregor is 87 years old and has been in the hospital for three days with fever,

nausea, and vomiting. She has on a pink nightgown that has brown stains down the front of it. Her vital signs are T: 99.6; P: 86; R: 20; B/P: 142/84. She has eaten a bowl of red Jell-O™ and a bowl of chicken broth. She drank a glass of apple juice and a can of Sprite™. She says she feels sick when she sits up but has not vomited at all today. Her right hand is numb, and holding anything with it is difficult. She has been to the bathroom three times. She says she cannot wait until her daughter comes this evening as the daughter is bringing pictures of Mrs. McGregor's granddaughter. She has watched TV most of the day.

a. What objective observations should be reported to the nurse?

____

____

b. Are there any observations that should be reported immediately?

____

____

c. Are there any subjective observations that you might make? If so, what are the observations?

____

____

4. Using the data above, give a change of shift report to a classmate.

____

____

____

5. Practice charting the data above on the sample forms provided by the instructor.

6. Examine an incident report form provided by the instructor. Practice filling out the incident report using the following information: The client's visitor, Mr. Jones, stood up from the visitor's chair to reach the paper on the bedside table. He lost his balance, fell against the client's bed, pushing it into the overbed table, on which were three plants that the client had received. The plants fell upside down on the floor. All the pots were broken and the plants crushed. They could not be salvaged. Mr. Jones cut his forearm on the rail of the bed and has a reddened area the size of a baseball surrounding the cut. An antibiotic ointment was applied to the cut and a bandage placed over the wound. Mr. Jones refused to have a physician called to look at the injuries. He denies any other injuries. The client, Mr. Smith, in room 201 was the only witness, and he is alert and

oriented. Mr. Jones's address is 1612 S. Park, Fallenborough, VA 10101, phone: (210) 339-3801.

7. Visit a local health care facility and observe how computers are used in the facility.

8. Visit a local health care facility's cafeteria, recreation room, or other public areas to observe and listen to what is being said and done.

   a. Was any inappropriate information discussed? ______________________________

   b. If the answer above is yes, how was confidentiality breached and what could have been done to maintain the confidentiality of client information?

      ____

      ____

      ____

      ____

9. To practice your client teaching skills, develop a plan for teaching your fellow students how to convert inches to their metric equivalent.

   ____

   ____

   ____

   ____

Unit Checklist

Student Name ____________________ Overall Unit Rating ________

Activity Sheet: The Team Approach to Quality Health Care Rating ________

Comments: ____________________

Activity Sheet: The Client as a Unique Individual Rating ________

Comments: ____________________

Activity Sheet: Communication Skills Rating ________

Comments: ____________________

Written Unit Evaluation Score ________

Additional Comments: ____________________

Teacher Signature ____________________ Date ________

Student Signature ____________________ Date ________

Unit IV

Safety

Hazards fill the health care environment. Keeping clients and workers safe is a challenge for any facility. Government agencies establish guidelines for safety in health care facilities. The facilities must remain in compliance with the guidelines to continue to operate. Since no guidelines govern home safety, nurse assistants who choose to work in home health must be especially alert for hazards to the personal safety of their clients and themselves and be aware of safety procedures carried out by the community.

Part of keeping clients safe includes protecting those who are vulnerable to infection by preventing the spread of infection from one client to another. The Centers for Disease Control and Prevention have established infection control guidelines. Health care facilities and workers should comply with these guidelines to prevent the spread of infectious diseases.

If nurse assistants follow these guidelines and know how to respond in a crisis, both they and their clients will be safer.

Unit Lessons

Guidelines for Safety

Home Safety Issues

Infection Control

Crisis Intervention

Lesson 1:
Guidelines for Safety

Objectives:

A. Identify OSHA safety standards.

B. Identify general guidelines for worker safety.

C. Describe hazards found in the health care industry.

D. Identify the components of a good safety program.

E. Describe risk management in a safety program.

F. Follow OSHA guidelines.

Key Terms:

- Hazard
- Occupational Safety and Health Administration (OSHA)
- Biological/infectious hazards
- Chemical hazards
- Environmental/mechanical hazards
- Ergonomic hazards
- Physical hazards
- Psychosocial hazards
- Risk management

The federal government establishes regulations that every industry, including health care, must follow to keep workers safe. The published regulations cover everything from hazardous chemicals to dangerous construction. This lesson provides a brief overview of these guidelines and how they affect the nurse assistant and other health care workers.

Occupational Safety and Health Administration (OSHA)

The **Occupational Safety and Health Administration (OSHA)** is the federal agency that sets health and safety standards to protect employees. The standards describe the limits of exposure to dangerous substances (such as chemicals and radiation), the safety programs that institutions must provide for their workers, and the conditions and procedures they must maintain.

General Guidelines for Worker Safety

Good safety practices protect both nurse assistants and those under their care. While some of OSHA's regulations are very specific, many are general, common sense guidelines. Following all employer safety and health regulations is just good practice. The regulations are designed to ensure that no one encounters undue **hazards** (any source of danger) in the workplace. For example, they require that the nurse assistant wear protective equipment when working around chemicals or infectious agents. Any hazardous conditions should be reported to the supervisor. If the supervisor is not concerned, or if the hazard is not corrected in a reasonable length of time, the nurse assistant should follow the chain of command until someone acts to correct the hazard. If no action is taken, the nurse assistant should contact the local OSHA office. According to OSHA regulations, an employee may refuse to work when faced with imminent danger of death or serious injury from hazards in the workplace.

Hazard Categories

Six categories of hazards are found in health care facilities. **Biological/ infectious hazards** are those that involve infectious agents transmitted by contact with infected clients or contaminated bodily secretions. Examples of this type of hazard are hepatitis, human immunodeficiency virus (HIV), tuberculosis, and lice. **Chemical hazards**, some of which are illustrated in Figure 1.1, are those presented by chemicals, such as medications, aerosols, vapors, and solutions, that are potentially toxic or irritating to a body system. Examples of chemical hazards found in health care settings are cleaning solutions, sterilizing agents, and drugs. If a nurse assistant has an allergy to latex gloves, the gloves would be a chemical hazard. **Environmental/ mechanical hazards** are elements in the work environment that can cause accidents, injuries, strain, or discomfort. Examples of these are unsafe equipment, poor air quality, and cluttered work areas and/or passageways, such as the one shown in Figure 1.2. **Ergonomic hazards** are related to the design or modification of a workplace to match human characteristics and capabilities. Examples of ergonomic hazards would be high beds, awkwardly placed handrails, and low chairs. The nurse assistant encounters these hazards when handling clients, such as when he or she lifts or positions a client. Good body mechanics can be used to deal with ergonomic hazards. **Physical hazards** are agents in the work environment that can cause tissue trauma, including combative clients, cold, heat, fire, electrical shock, radiation, and sharp objects. **Psychosocial hazards** are factors or situations that may cause stress, emotional strain, and/or interpersonal problems. Examples of this type of hazard are aggression or violence by clients, changes in or varying shift work, and high-pressure assignments.

Figure 1.1 - Chemical Hazards

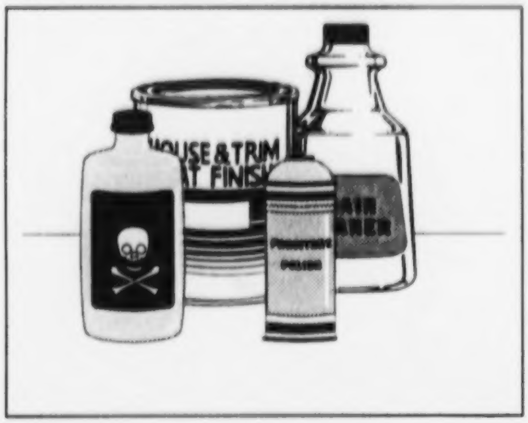
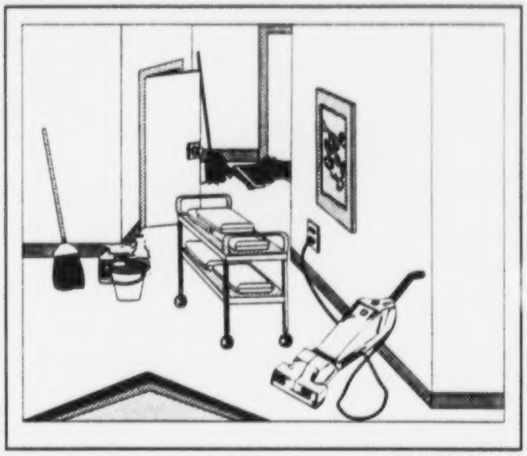


Figure 1.2 - Environmental/Mechanical Hazards



OSHA Safety Program

OSHA requires that every workplace have a safety program in place. Management, leadership, and employee participation are necessary components of a good safety program. The nurse assistant may be asked to be on a safety committee to provide information regarding hazards and recommendations for the elimination of those hazards. As a member of a safety committee, the nurse assistant will help monitor safe working conditions and possibly conduct safety inspections.

The safety program should contain an analysis of the workplace to determine what hazard categories are potential problems at the facility. The analysis team should walk through the facility to see which hazards exist and then decide how to deal with them. **Risk management** is recording and tracking of all existing or potential hazards within a workplace and establishing policies and procedures to deal with these hazards if or when they occur. Facilities must keep a record of all accidents and detailed reports of each injury or illness resulting from them. By doing so, a facility can identify common causes of accidents or illnesses and take measures to prevent them from recurring. Many facilities have a risk management department or an employee who is responsible for the collection and analysis of data about accidents, injuries, and illnesses. The incident report (discussed in Unit III, Lesson 3) may be filed with this department or employee.

All facilities must have policies and procedures for hazard prevention and control. These policies may be administrative in nature, or they may be nursing procedures, such as how to lift, turn, transfer, and ambulate a client. They also define any required personal protective equipment, such as clothing, gloves, masks, and eye protection. The policies may include detailed procedures for medical control measures, such as annual tuberculosis skin testing or chest x-rays. The facility must have an emergency response system in place. Fire drills are conducted routinely in health care facilities so employees can practice their responses and be better prepared if an actual emergency occurs. Safety and health training must be provided by the facility, and documentation of employee attendance at the training kept on file. This requirement is why facilities have presentations during employee orientation and annual in-service presentations on infectious diseases, chemicals, fire safety, general safety policies, and body mechanics. Other topics may be covered if incident reports show a need for them.

The written safety policies of facilities may vary slightly. When a nurse assistant starts work in a new setting, he or she should become familiar with the established policies and incorporate them into their work routine.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 1: Guidelines for Safety

Activity Sheet

1. Who sets the standards for safety in the workplace?

   ____

2. What are the three areas that safety standards address?

   a. ______________________________

   b. ______________________________

   c. ______________________________

3. What are the five general guidelines for worker safety that the nurse assistant should follow?

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

   e. ______________________________

4. Define and give an example of each of the six types of hazards.

   a. Biological/infectious hazards ______________________________

   ____

   ____

   b. Chemical hazards ______________________________

   ____

   ____

c. Environmental/mechanical hazards ______________________

____

____

d. Ergonomic hazards ______________________

____

____

e. Physical hazards ______________________

____

____

f. Psychosocial hazards ______________________

____

____

5. List the three components of an OSHA safety program.

a. ______________________

b. ______________________

c. ______________________

6. What is the purpose of a risk management department or person?

____

____

____

Clinical/Laboratory Activities

1. Identify safety hazards that may be present at school or at home. (List one hazard from each of the six categories.)

School Hazards	Home Hazards
a. ______________________	a. ______________________
b. ______________________	b. ______________________
c. ______________________	c. ______________________
d. ______________________	d. ______________________
e. ______________________	e. ______________________
f. ______________________	f. ______________________

2. Review a copy of the school safety policies.

   a. What are the most important safety issues for the school?

   ____

   ____

   b. What changes could be made to improve the safety of the students?

   ____

   ____

   ____

   ____

Lesson 2:
Home Safety Issues

Objectives:

A. Identify home safety concerns and potential hazards to the client in the home.

B. Respond appropriately to hazards and home safety concerns.

C. Describe possible emergencies that may occur in the home.

D. Identify appropriate actions to take during emergencies in the home.

E. Describe possible emergencies that may occur in the community.

F. Respond appropriately to community emergencies.

G. Review the home safety plan with the client and others providing care in the home.

H. Carry out the home safety plan if an emergency occurs during the home visit.

Key Terms:

- Poisoning
- Antidote
- Natural disaster
- Home safety plan

Safety measures for the client and the environment presented in the *Health Care Assistant Core* curriculum addressed the institutionalized client. Some of the safety measures used in health care facilities will also apply to the home environment; others will be specific to the home. Because nurse assistants working in home care have an independent role and no ancillary personnel, such as maintenance workers, to assist with the environment, they will need to be skilled at identifying hazards.

Since nursing care is provided in the client's own environment, the client must decide whether to make changes to correct safety hazards or not. The client may not be able to afford purchasing safety devices or hiring someone to do tasks such as installing grab bars in the bathroom. The home health aide can observe and report hazards and even suggest possible changes that would enhance safety, but changes cannot be made without the client's permission.

Home Safety Concerns and Potential Hazards

More accidents occur in the home than in any other place. The home is full of potential hazards that healthy people navigate without difficulty and often without conscious thought. A person who is ill or has impaired mobility may not have the strength or ability to avoid potential hazards. There is no regulatory agency that requires a home to be inspected for compliance with safety standards. Therefore, it becomes the responsibility of the health care worker who visits the home to identify concerns and hazards and to take steps to remove them with the client's approval.

The general rules for safety are much the same as those rules identified in the *Health Care Assistant Core* curriculum. Additional measures, specific to the home environment, include the following:

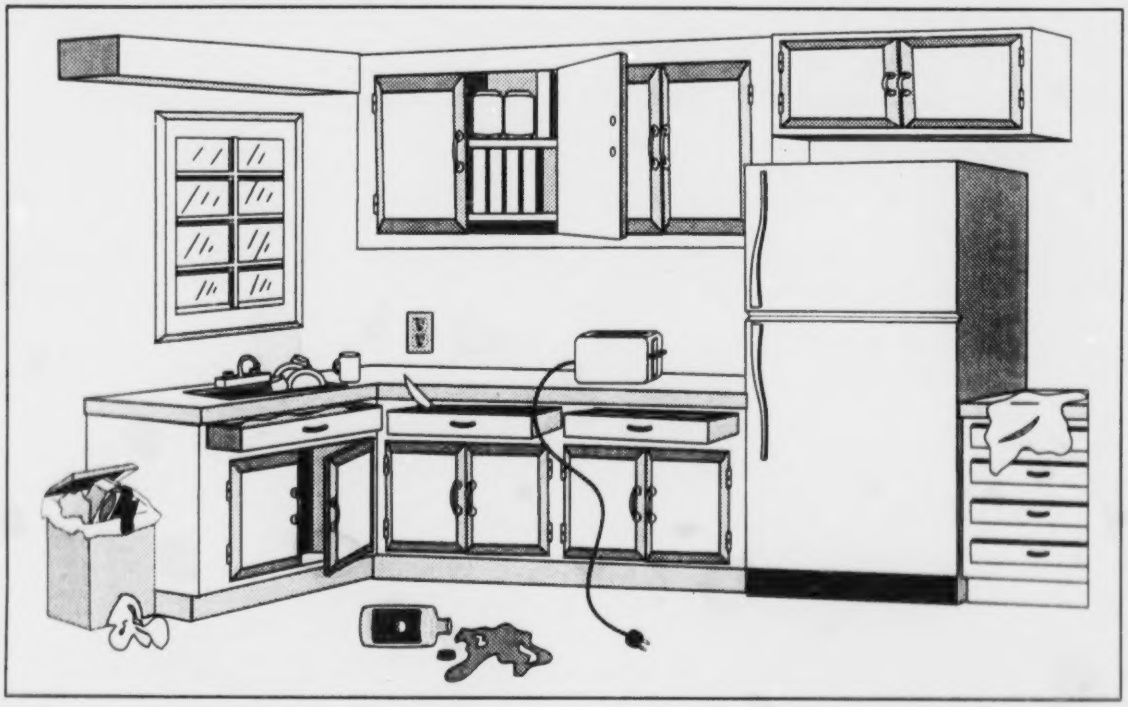
- Identify a method of communication with one's supervisor if no telephone is available.
- Carry a list of emergency numbers and post a list near the telephone if one is available.
- Do not attempt to utilize a piece of equipment if you are unsure how to operate it.
- Do not attempt to change fuses or throw circuit breakers unless you are familiar with these procedures.
- Read the label of a substance before using it; do not use any unlabeled substances.
- When caring for a child, close and lock (or guard) doors to stairways and the kitchen.
- Keep Venetian blind cords out of reach of children.
- With the client's permission, put all poisons in a locked, secure place.
- Check the hot water temperature in all taps because the temperature setting may need to be lowered to prevent burns to young children or the aged whose skin is more sensitive; a temperature of 120 degrees Fahrenheit is the maximum setting for safety.
- Check smoke detectors routinely to be sure they are functioning; if none are present, suggest that the client install them.

Each room of the house has potential hazards that the home health aide must address. In the living room, the client usually has the furniture arranged to his or her liking. However, the home health aide should check for potential hazards, such as obstructed pathways to chairs and sofas, sharp edges on furniture, and rolling furniture that will move if someone falls against it. Small objects on the floor; rough edges, loose strings, or exposed tacks on carpeting; and electrical cords running through walkways, under rugs, and through doorways can all trip the client. The client's attention should be drawn to the safety hazard and suggestions for improvement given, although changes should only be made at the request of the client. If the client agrees, furniture can be rearranged to clear obstructed pathways, unstable furniture can be moved against the wall, and furniture with sharp edges and small objects can be moved out of the way. Electrical cords could be moved to pass behind furniture. If possible, carpeting should be in good condition. Potential hazards should also be reported to the home health aide's supervisor.

The kitchen is a particularly hazardous place. Some possible safety hazards are shown in Figure 2.1. Falls, electric shock, burns, or poisoning can all occur in the kitchen. When working in the client's kitchen, the home health aide should observe several safety precautions. Food should not be left unattended in the oven or on the stove. Flammable items should be kept away from the stove. If the client has a pacemaker and a microwave oven is utilized during cooking, the client should stay out of the immediate area. Floors should be kept free of spills and debris; tile and linoleum floors should be left unwaxed. Drawers and cabinet doors should be kept closed. The home health aide may suggest other safety measures to the client, such as an all-purpose fire extinguisher to be kept in the kitchen and storing frequently used items within easy reach to reduce climbing and/or bending. To prevent accidents, electrical appliances and cords should be placed well away from both the edge of counters and the sink. Cleaning solutions should be stored away from food storage areas in a location that is either kept locked or is not easily accessible.

The bathroom is another room in which accidents frequently happen. Many falls occur in the bathroom due to wet, slippery

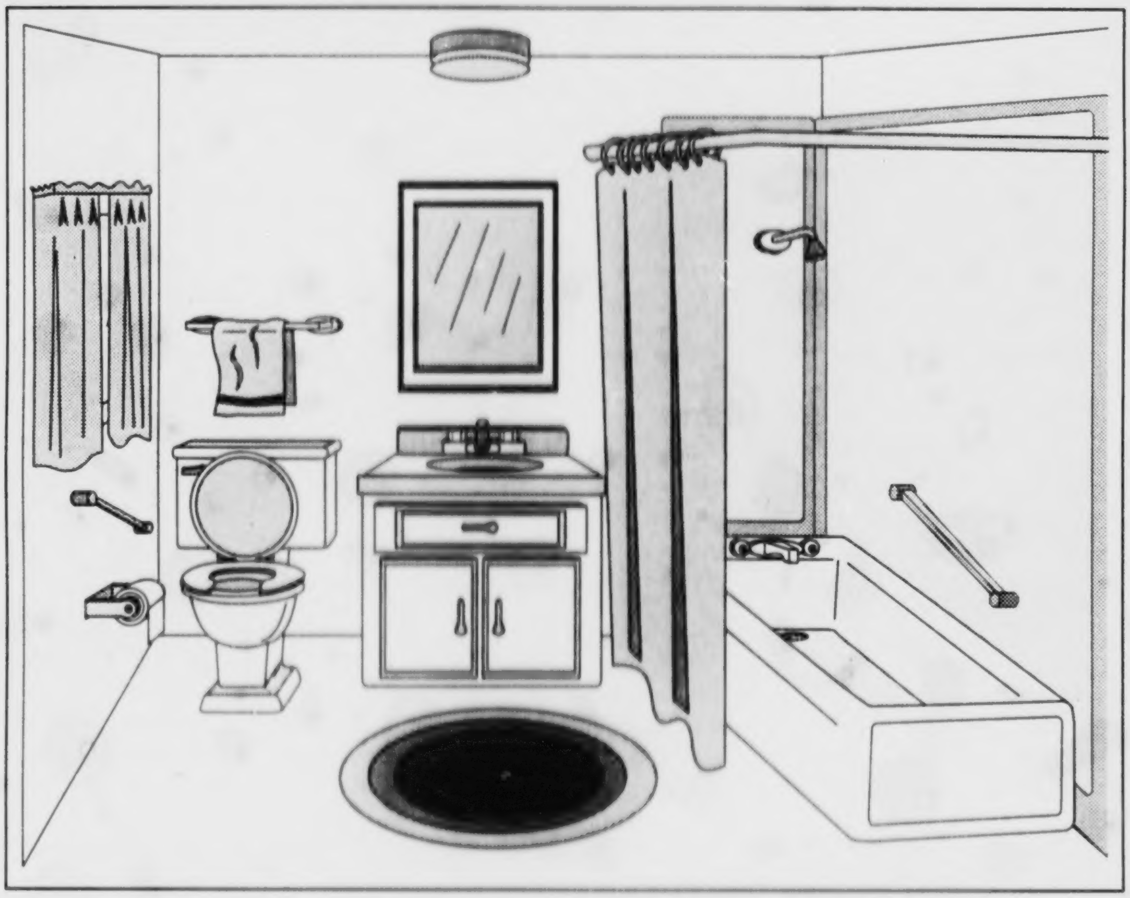
Figure 2.1 - Safety Hazards in a Kitchen



floors. Care should be taken to keep water off the floor during personal hygiene tasks. If water is spilled or dropped on the floor, it should be wiped up immediately. The home health aide may suggest purchasing a secure bath mat for the floor and non-skid rubber decals or strips for the tub or shower. Towel bars are not designed to support body weight. If the client needs the support of a bar when getting out of the tub, shower, or up from the toilet, the aide may recommend that special grab bars be installed as illustrated in Figure 2.2. He or she may also suggest that a raised toilet seat be installed if the client has difficulty sitting down on and rising from one at a standard height. If the client cannot get in and out of the tub safely, a tub chair or bench may be recommended for his or her use. Bathing can make the client weak; if the client gives his or her permission, placing a chair in the bathroom allows the client to sit down if he or she becomes weak while taking care of personal hygiene needs. With the client's consent, breakables such as drinking glasses and ceramic toothbrush holders should be removed from the bathroom to prevent the possibility of cuts. The faucets should be correctly marked for hot and cold water. Electric appliances should not be used in the bathroom.

Many clients may spend a good portion of each day in the bedroom, particularly if their strength does not allow them much mobility. The home health aide should suggest that the bed be about knee-height to allow the client to get in and out easily and that the pathway to the door be kept clear of obstacles. The aide might also recommend that a night-light be used and that a bedpan or commode be kept at the bedside for nighttime use. When working with the client, he or she should check the client's clothing for any loose areas that might catch on doorknobs or other objects; slippers should be checked to make sure

Figure 2.2 - Grab Bars in a Bathroom



they fit properly to prevent falls. The aide should keep drawers and doors to chests, dressers, and closets closed.

The client may face many additional hazards if he or she is able to go outside. The client should always make use of handrails if they are available. The home health aide can suggest that all steps be clearly marked with a stripe of contrasting paint on the edge of the step to help the client identify where the step is. If available, supportive walking shoes with nonslip soles and walking aids, such as canes and walkers, should always be used by the client. The aide may recommend that the client avoid going out at night, since potential dangers are not as easily seen in the dark, and that trips outside be postponed during inclement weather, since walking surfaces will be slippery. The client may be able to purchase food, clothing, or other necessary items by telephone from a grocery or drug store that delivers, or by ordering from a catalog.

Clients in the home may be using oxygen. The safety measures for oxygen were presented in the lesson on oxygen therapy in the *Health Care Assistant Core* curriculum and should be reviewed. In addition to the measures identified there, the following should also be applied in the home.

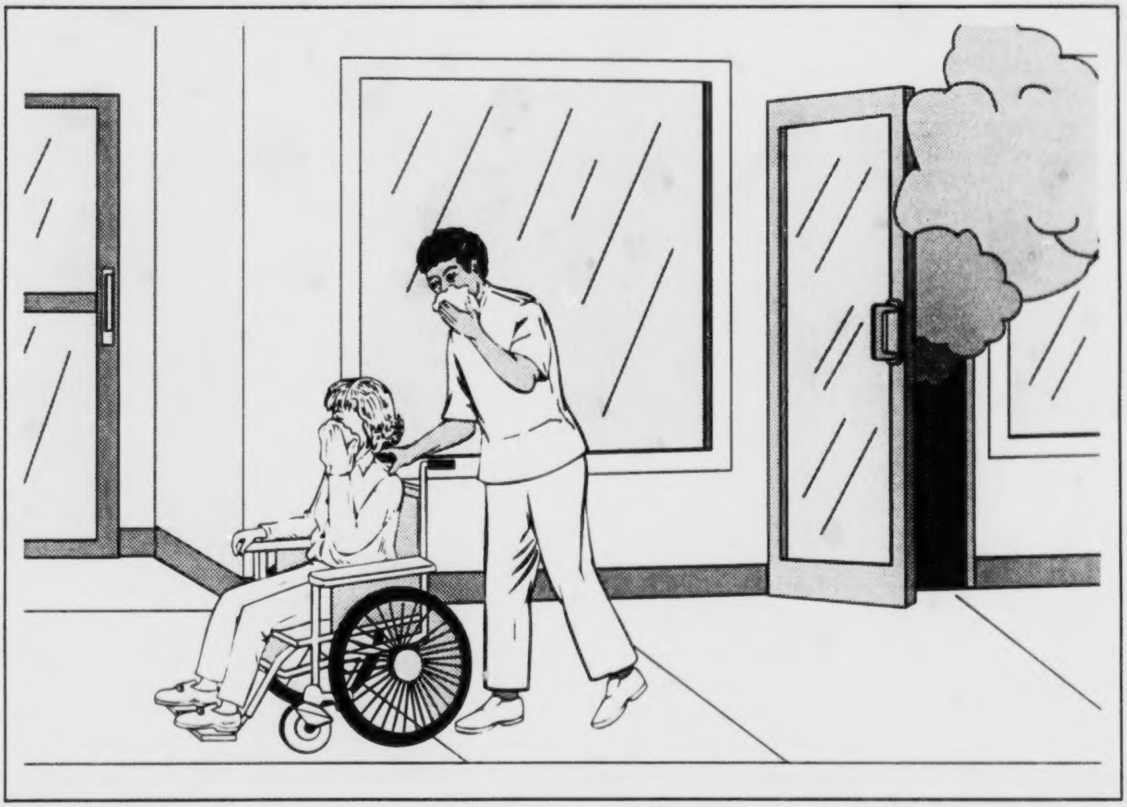
- No candles or open flames, such as a fireplace, should be used.
- Use care in combing the client's hair since static electricity is sometimes generated.
- Check with the oxygen distributor for instructions on how to work and maintain the oxygen system.
- The oxygen tubing may be fairly long to allow the client to leave the tank in the bedroom and walk to the bathroom while using the oxygen. The trailing oxygen tubing presents a safety hazard. A system should be developed to coil and uncoil the tubing so the client does not trip and the tubing is kept out of the way when not in use.

Practicing good body mechanics may also be a challenge for the home health aide. The client's home may not have some of the devices, such as electric beds that elevate to a comfortable working height found in a health care facility. To prevent personal muscle strain and injury, the home health aide will need to be sure to follow the guidelines for proper body mechanics in lifting, moving, and completing procedures.

Emergencies in the Home

Poisoning can occur with children, confused adult clients, or those clients who choose this means to attempt suicide. **Poisoning** occurs when any substance, harmful to the body, is ingested. Some possible sources of poison include cleaning fluids, excessive medication, and spoiled food. If poisoning is suspected, the

Figure 2.3 - Evacuation Procedures



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supervisor should be notified immediately. If the ingested substance can be identified, the poison control center can perscribe an **antidote,** which will counteract the effect of the poison in the body.

A fire is probably the most common and the most feared household emergency. When a fire occurs, the home health aide may be able to put out a small fire by cutting off the supply of oxygen or removing the source of heat. However, he or she should first determine if the client or others in the house are in immediate danger. If so, the house should be evacuated. The home health aide should take charge of getting the client out of the house. Clients who are ambulatory or in wheelchairs should be guided out as rapidly and safely as possible. Smoke is just as dangerous as an actual flame; when inhaled for a period of time, it can cause death. If the smoke is dense, everyone leaving the house should cover his or her nose and mouth with wet cloths. Proper evacuation procedures are shown in Figure 2.3. A client who is not ambulatory can be rolled onto blankets, his or her mouth and nose covered with wet cloths, and then pulled out on the blankets. The aide should never reenter a smoke-filled, burning house. The fire department can be notified from a neighbor's house. If clients have limited mobility, are disabled, use oxygen, or live alone, they can be registered with the fire department so firefighters are aware of the situation if a fire alarm is called in. Figure 2.4 identifies some other fire safety tips.

Fire is a very traumatic event. The client should be kept as comfortable as possible and given support. The supervisor should be notified as soon as the client is no longer in danger and the fire department has arrived. Because of the emotional trauma the client may sustain, the home health aide will generally have to stay longer than usual. The supervisor may need to make arrangements to have another home health aide care for clients on that day's schedule.

Emergencies in the Community

Most communities have an emergency-preparedness plan or disaster-planning measures for flooding, tornadoes, and earthquakes. Some communities will have

Figure 2.4 - Tips for Fire Management

- If the home has a fire extinguisher, the home health aide should know what type it is and how to use it. If an improper fire extinguisher is used, the fire may be spread rather than extinguished.
- When evacuating the home during a fire, always check to see whether a closed door is warm before opening it during a fire. If it is hot, the door should remain closed and another route taken.
- Electrical equipment, such as a stair lift, should not be used during a fire.
- When evacuating the home, the aide and residents should close doors to contain the fire as much as possible.
- Neither the aide nor the client should enter a room in which evidence of a fire exists. Fire spreads very rapidly, often within a few minutes.
- If fire traps the aide and the client in a room, they should keep the door closed and roll up a blanket or a rug to place along the bottom of the door. They should then open a window and attract the attention of rescuers.

more extensive measures planned for one or more of these **natural disasters**, or disasters caused by the forces of nature. Communities located near a river that has no water control measures may be more concerned about flooding. Those communities that are located in tornado- or earthquake-prone areas might have detailed emergency measures in case they occur. Home health aides should be aware of any general plans for emergency preparedness in the communities in which they have clients.

If flooding occurs, clients may need to be moved from the area sooner than other residents because access to medications, tanks of oxygen, food, electricity, or other substances upon which they depend may be cut off by the flood waters. Usually, some time to prepare for this emergency is available, and plans should be discussed with clients and others regarding where they might go and how they would get there. The home health agency and all others involved in the care of clients should be aware of any changes of residence during the emergency.

An earthquake occurs with very little warning. If the home health aide is in a client's home when a tremor occurs, he or she should see that the client is protected from falling objects. If the earthquake is severe, the aide should move the client outside, away from buildings that might collapse and power lines that might fall. If the earthquake is severe enough to disrupt power and water supplies, the home health aide should stay with the client. The agency's or community's disaster plan will go into effect immediately, and the home health aide should follow those guidelines. The home health aide's primary responsibility is to the client with whom he or she is working with at the time of the emergency.

A tornado can also occur without warning, although weather conditions usually indicate when a tornado is possible. If tornado sirens sound while the home health aide is caring for a client, he or she should move the client to a safe area in the house. Again, the home health aide should remain with the client until the all-clear signal sounds. If the tornado strikes the home, and the client is injured, basic first aid measures should be preformed and the client should be kept comfortable until assistance arrives.

The *Health Care Assistant Core* curriculum discusses tornado and earthquake safety. The home health aide should review that information as some of the general principles are applicable to working within clients' homes.

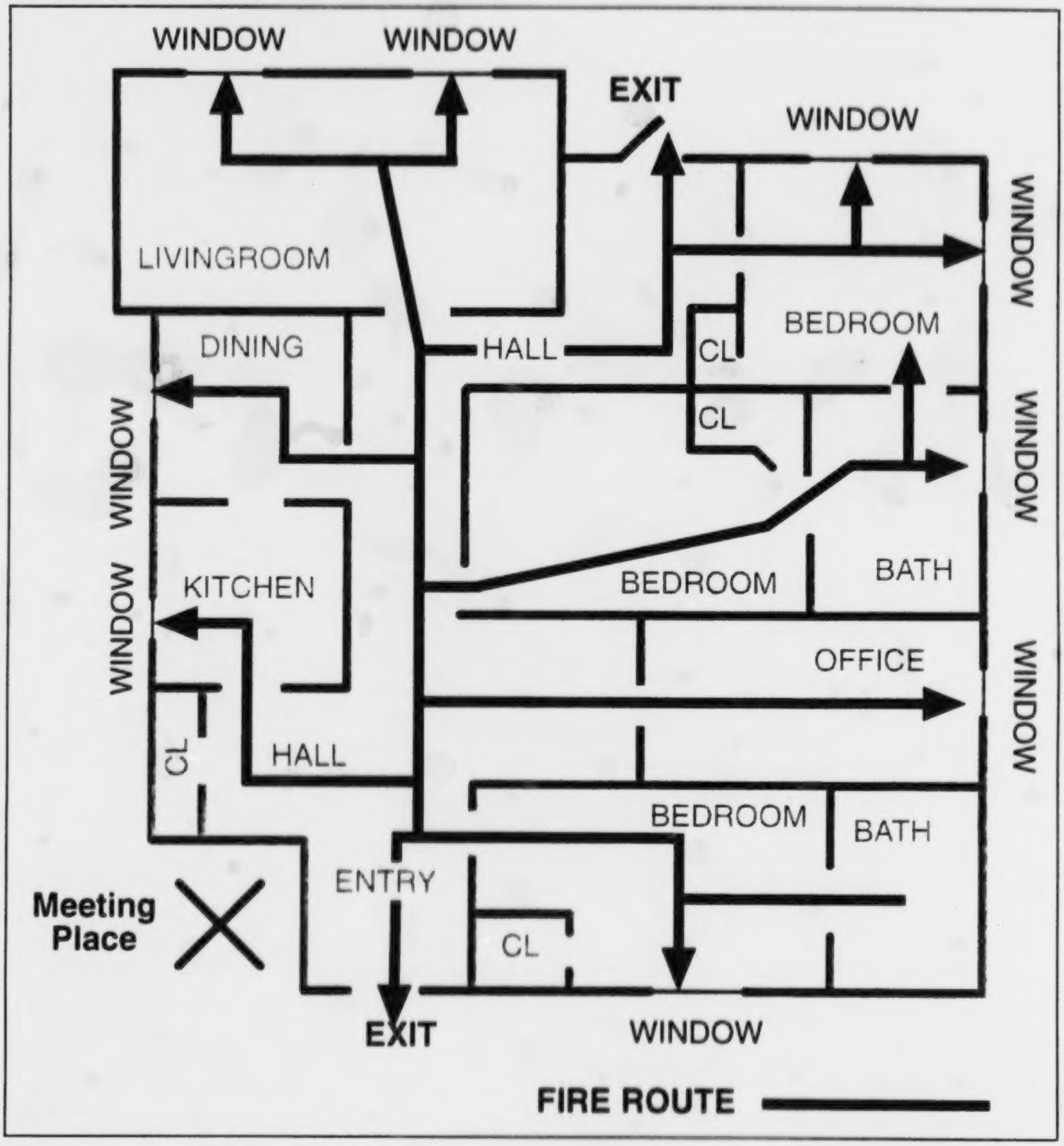
In any natural disaster, communication with the supervisor or emergency personnel may be impossible. The home health aide should find some alternative means of notification as soon as possible.

Home Safety Plan

A **home safety plan** is a plan establishing what each person in the home will do if an emergency, such as a fire or natural disaster, occurs. Every home should have a plan. In some instances, it may be very simple, such as alternate residences to which the client could go if a natural disaster occurs. In other instances, the plan may need to be practiced prior to the emergency, such as planned escape routes for a fire. If the client requires life-sustaining equipment, such as a ventilator, an emergency power source will be needed for situations in which public utility power is interrupted.

If the client has no fire plan, the home health aide may need to assist in creating one. A sample fire plan is shown in Figure 2.5. The fire plan should be as simple as possible; during emergencies people tend to be too excited to remember complex instructions. All possible exits should be identified. This includes windows that are low enough to allow people to drop to the ground without harm or to which an escape ladder can be attached. An escape route should be identified for each room. If a fire extinguisher is present, everyone should know its location and how to use it. The fire extinguisher should be checked routinely to ensure that it is in working condition. An outside meeting place should be chosen so that everyone can be accounted for as soon as possible. After making sure that a plan is in place, the home health aide should consider how the client could be removed from the house in

Figure 2.5 - Sample Fire Plan


WINDOW
WINDOW
EXIT
WINDOW
WINDOW
LIVINGROOM
DINING
HALL
CL
BEDROOM
CL
WINDOW
WINDOW
WINDOW
KITCHEN
BEDROOM
BATH
OFFICE
WINDOW
CL
HALL
BEDROOM
BATH
ENTRY
Meeting Place
CL
EXIT
WINDOW
FIRE ROUTE

any situation, particularly if the client has limited mobility.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 2: Home Safety Issues

Activity Sheet

1. Identify six safety measures specific to the home environment.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

   e. ______________________________

   f. ______________________________

2. How could one potential hazard found in each of the following areas be corrected, if the client agrees to the necessary changes?

   a. Living room ______________________________

   b. Kitchen ______________________________

   c. Bathroom ______________________________

   d. Bedroom ______________________________

   e. Outside the house ______________________________

3. Identify two safety measures to be followed if the client is using oxygen at home.

   a. ______________________________

   b. ______________________________

4. If the home health aide suspects that a client has ingested poison, what should be done?

   ____

   ____

   ____

5. Identify the six tips for fire management.

   a. ____________________

   b. ____________________

   c. ____________________

   d. ____________________

   e. ____________________

   f. ____________________

6. What should the home health aide do in the event of a flood?

7. What should the aide do if an earthquake begins while he or she is in a client's home?

8. What are the home health aide's responsibilities during a tornado if the sirens sound while he or she is caring for a client?

9. Describe a home safety plan.

Clinical/Laboratory Activities

1. Visit the home of a friend, relative, or neighbor. Identify the hazards that are found in the living room, kitchen, bathroom, bedroom, and outside the home. Describe how those hazards could be corrected to make the home safer for someone who might be ill or have restricted mobility.

2. Search your home for potential poisons. Where are they located? Should they be moved, and if so, where should they be stored?

3. Based on the information provided by the fire department and contained in this lesson, what changes should be made in your home to keep you and others safe from fire?

4. Develop a safety plan for your home.

Lesson 3:
Infection Control

Objectives:

A. Identify infectious diseases currently affecting nursing.

B. Differentiate between types of isolation precautions.

C. Apply CDC isolation precautions to client situations.

D. Adapt infection-control procedures to limitations in the home.

Key Terms:

- Nosocomial infections
- Human immunodeficiency virus (HIV)
- Acquired immunodeficiency syndrome (AIDS)
- Hepatitis B (HBV)
- Tuberculosis (TB)
- Pneumonia
- Medication resistant
- Multidrug-resistant
- Isolation precautions
- Centers for Disease Control and Prevention (CDC)
- Standard precautions
- Transmission-based precautions
- Airborne precautions
- Droplet precautions
- Contact precautions
- Regulated medical waste

Microorganisms produce many types of infectious diseases. Some are minor, like colds or flu. Others are serious enough that a client requires the services of a health care facility. Health care facilities are concerned that clients who come into the facility with infections do not pass them on to other clients who may be susceptible. Infections acquired in a health care facility are called **nosocomial infections**. Facilities have procedures by which infections can be prevented and contained.

Infectious Diseases Affecting Nursing

An infectious disease that continues to receive a lot of publicity is **human immunodeficiency virus (HIV)**. HIV is a virus that attacks cells in the body and eventually impairs the body's immune system. The virus is spread by contact with infected blood or other bodily fluids. An individual can be HIV infected but have no symptoms; they are diagnosed as HIV positive. Once symptoms appear (the last stage of an HIV infection), the individual is considered to have **acquired immunodeficiency syndrome (AIDS)**. The symptoms of AIDS can include a dry cough, loss of appetite and weight, night sweats, diarrhea, extreme fatigue, swollen lymph glands, external and internal rashes, and neurological disorders. AIDS is a fatal disease with no known cure.

The form of hepatitis for which the health care facilities have preventive measures is **hepatitis B (HBV).** It is an infectious contagious disease of the liver caused by a virus found in the body fluids of an infected person that produces flu-like symptoms. An employer must make the hepatitis B vaccine and vaccination series available to all employees who have occupational exposure to blood and body fluids.

Tuberculosis (TB) is a infectious bacterial disease spread by airborne droplets when an infected person coughs, sneezes, or laughs. The organism implants itself in the lung, causing inflammation. The infected person develops a cough, dyspnea (shortness of breath), general malaise, a low-grade fever, and night sweats. Socially and economically disadvantaged persons and alcoholic and malnourished individuals are most often affected. Men are affected more often than women; a great number of cases occur in persons over the age of 65.

Pneumonia is an inflammation of the alveoli in the lungs caused by organisms that can be bacterial, viral, or fungal in nature. The symptoms are a cough with green or rust-colored sputum; rapid, shallow respirations; fever; chills; chest pain; and general malaise. The infection affects infants and the elderly most often, generally in the winter and early spring. The client in a facility who is weakened and bedfast is particularly susceptible.

Since the development of antibiotic therapy in the late 1940s, infections have been much easier to manage. Drug companies have continued to develop antibiotics that specifically work against certain infection-producing organisms. Those organisms have in some cases been able to change their structure so that the antibiotic no longer harms or kills them; they are thus referred to as **medication resistant**. Some organisms have developed a resistance to many different antibiotics and are called **multidrug-resistant** organisms. This trend is of concern to health care workers since there is no longer a guarantee that a medication will be able to eradicate an infection. The health care worker must therefore take responsibility for preventing infections.

Types of Isolation Precautions

Isolation precautions refer to the specific procedures and precautions designed to prevent a client from infecting others or being infected by others. It may involve housing the client in a separate room. The **Centers for Disease Control and Prevention (CDC)**, the United States Department of Health and Human Services that deals with the prevention and control of infectious diseases, identifies two general types of isolation precautions for institutionalized clients: standard precautions and transmission-based precautions. **Standard precautions**, as listed in Figure 3.1, are the isolation procedures that should be used with every client whether or not an infectious organism has been identified; every client is treated as if he or she were potentially infectious. Standard precautions reduce the risk of transmission of bloodborne pathogens and pathogens from moist body substances. Standard precautions apply to blood, body fluids, secretions and excretions (except sweat), non-intact skin, and mucous membranes. (Standard precautions include and replace the universal precautions and body substance isolation practices previously used for infection control.)

The CDC states that handwashing is the single most important measure to reduce the risks of transmitting microorganisms from one person to another or from one site to another on the same client. The procedure for handwashing is discussed in the *Health Care Assistant Core* curriculum and should be reviewed.

When using standard precautions, hands should be washed at the following times: after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; before donning gloves; after gloves are removed; between client contacts and at other times when a danger of transfer of microorganisms exists; and between tasks and procedures on the same client to prevent cross-contamination. A plain (nonantimicrobial) soap is used for routine

Figure 3.1- Standard Precactions

- **Handwashing.** Hands must be washed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; before donning gloves; after gloves are removed; between client contacts; and between tasks and procedures on the same client. Nurse assistants who have open cuts, sores, etc., on their hands must wear gloves for all client contact.
- **Gloves.** Gloves must be worn when touching blood, body fluids, secretions, excretions, and contaminated items and before touching mucous membranes and broken skin. Gloves should be changed between tasks and procedures on the same client, between tasks on different clients, removed immediately after use and before touching noncontaminated items or environmental surfaces.
- **Mask and protective eyeware (face shield).** A mask, eye protection, or a face shield must be worn during procedures that can cause splashes or sprays of blood, body fluids, secretions, and excretions.
- **Gowns.** Gowns must be worn during procedures or situations where there may be exposure to blood, body fluids, secretions, or excretions.
- **Transportation.** When transporting any client, appropriate precautions must be taken to minimize the risk of infection to other clients, personnel, visitors, environmental surfaces and equipment.
- **Client care equipment.** Client care equipment must be adequately cleaned and disinfected after use or whenever it becomes soiled with blood, body fluids, secretions, and excretions. Disposable, single-use equipment should be discarded properly and immediately.

handwashing. An antimicrobial agent or a waterless antiseptic agent may be used for outbreaks of specific infections. Handwashing is illustrated in Figure 3.2. Washing hands as promptly and thoroughly as possible at the times listed above is an important component of infection control and standard precautions. In addition to handwashing, gloves play an important role in reducing the risks of transmission of microorganisms.

Gloves are worn to prevent blood and body fluids from contaminating the health care worker's hands, to prevent organisms on the health care worker's hands from contaminating the client, and to prevent the transmission of organisms from client to client. Failing to change gloves between client contacts is an infection control hazard. Wearing gloves does not replace the need for hand washing, since gloves may have small, nearly invisible defects or become torn during use. Likewise, the health care worker's hands can become contaminated during removal of gloves. Figure 3.3 shows a nurse assistant donning gloves. The procedure for donning and removing daily-care, nonsterile gloves is outlined in the *Health Care Assistant Core* curriculum and should be reviewed.

Gloves should be worn when touching blood, body fluids, secretions, excretions, and contaminated items and before touching mucous membranes and broken skin. Gloves should be changed between tasks and procedures on the same client after contact with material that may contain microorganisms; they should be changed between clients as well. Gloves should be removed immediately after use. They should also be taken off before touching noncontaminated items and environmental surfaces.

Other personal protective equipment may also be used as a part of standard precautions. A mask, eye protection, or a face shield should be worn to protect the mucous membranes of the health care worker's eyes, nose, and mouth during procedures that can cause splashes or sprays of blood, body fluids, secretions, and excretions. A clean, nonsterile gown should be worn to protect the skin of the health care worker and to prevent the contamination of his or her clothing during procedures where blood, body fluids, secretions, or excretions are present. The procedure for donning and removing masks and gowns is outlined in the *Health Care Assistant Core* curriculum and should be reviewed.

Limiting the movement and transport of infected clients and ensuring that such clients leave their rooms only for essential purposes reduces the opportunity for transmission of microorganisms within the health care facility. When client transport is necessary, appropriate precautions must be taken to minimize the risk of infection to other clients, personnel, visitors, environmental surfaces and equipment.

Figure 3.3 - Donning Gloves

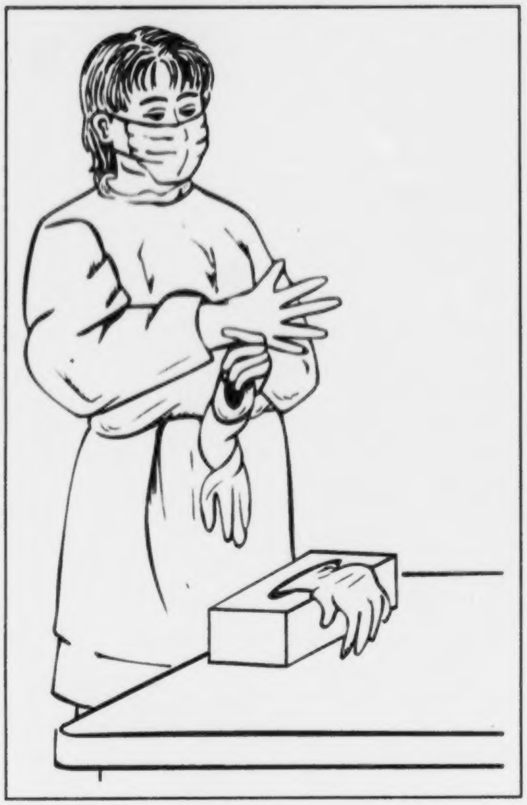
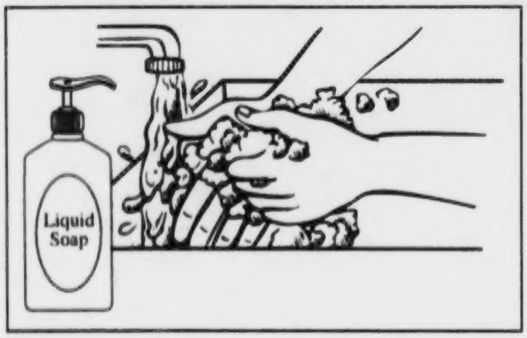


Figure 3.2 - Handwashing



Any client care equipment that is soiled with blood, body fluids, secretions, and excretions should be handled in such a way as to prevent contact with skin, mucous membranes, and clothing and to prevent transfer of microorganisms to other clients and environments. Disposable, single-use equipment should be discarded properly and immediately. Reusable equipment should be adequately cleaned and disinfected according to facility policy. Each facility will have environmental control procedures for care, cleaning, and disinfection of environmental surfaces, beds, bed rails, and bedside equipment. For information regarding the proper treatment of linen, sharps, laboratory specimens, waste disposal, CPR and client placement, review the *Health Care Assistant Core* curriculum.

Transmission-based precautions are the isolation procedures used for clients that are known to be infected or for those suspected of having an infection. Three types of precautions may be used. They can be used separately or in combination, depending on the type of infection or if

Figure 3.4 - Transmission-Based Precautions

AIRBORNE PRECAUTIONS

- **Always use standard precautions.**
- **Client placement.** The client should be placed in a private room that has a special airflow design with the door closed. If a private room is not available, the client preferably would be placed in a room with a client who has the same infectious process. If this is not possible, an infection control specialist should be contacted for advice on client placement.
- **Masks and eyewear.** A surgical mask should be worn upon entering the room.
- **Transportation.** The client should be restricted to the room and not transported to other areas of the facility. If transport is essential, the client should wear a surgical mask.

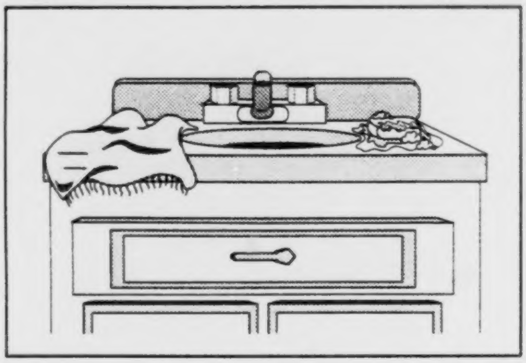
DROPLET PRECAUTIONS

- **Always use standard precautions.**
- **Client placement.** The client should be placed in a private room. If a private room is not available, the client preferably would be placed in a room with a client who has the same infectious process. If this is not possible, a spatial separation of at least three feet should be maintained between the infected client and other clients.
- **Masks and eyewear.** A surgical mask should be worn when working within three feet of the client. (Some facilities may choose to require health care workers to wear a mask when entering the room.)
- **Transportation.** The client remains in the room for all except essential transports. If transport is necessary, the client should wear a surgical mask.

CONTACT PRECAUTIONS

- **Always use standard precautions.**
- **Client placement.** The client should be placed in a private room. If a private room is not available, the client would preferably be placed in a room with a client who has the same infectious process. If this is not possible, an infection control specialist should be contacted for advice on client placement.
- **Gloves.** Gloves should be worn when entering the room and changed after every contact with infectious material. Gloves are removed before exiting the client's room. Hands are washed immediately after any contact with potentially contaminated environmental surfaces.
- **Gowns.** A gown is worn when entering the room if any potential exists for contact between clothing and the client, environmental surfaces, or items in the client's room. The gown is removed before leaving the client's room, insuring that clothing does not touch any potentially contaminated environmental surface.
- **Transportation.** The client should remain in the room. If transport is necessary, the area of contact should be covered and the risk of transmission minimized as much as possible.
- **Client care equipment.** Equipment should not be shared with other clients. If the use of common equipment is unavoidable, the item should be disinfected before it is used with another client.

Figure 3.5 - Home Infection Control Dangers



multiple infectious agents are present. **Airborne precautions** are used when the infectious agent is carried in the air and can be inhaled. Airborne precautions would be used for tuberculosis. **Droplet precautions** are used when the infectious agent is transmitted in droplets (through sneezing, for example) to the mucous membranes of another person. Droplet precautions would be used for pneumonia and influenza. **Contact precautions** are used when the infectious agent is transmitted either directly (through body to body contact) or indirectly (through an intermediate object). Examples of infections that would require contact precautions are those caused by multidrug-resistant bacteria in wounds. Contact precautions are also used if parasites such as scabies or lice are present. Figure 3.4 list steps to take for each of these types of precautions. (Transmission-based precautions include and replace the following categories of isolation previously used for infection control: strict, contact, respiratory, and tuberculosis isolation; and enteric and drainage/secretion precautions.)

Adapting Infection Control to Home Care

The home health aide will need to carry certain supplies to the home to carry out infection control measures. Handwashing can be carried out in the home as well as in a health care facility, but the home may not have paper towels or liquid soap available. Figure 3.5 shows home infection control dangers. Cloth towels that are used by the client and others in the home will carry microorganisms and should not be used by the home health aide. Bar soap usually sits in soapy residue that can be a breeding ground for microorganisms, so liquid soap is preferable for hand washing. If running water is not available in the home, the home health aide should carry a waterless antiseptic agent to be used in place of the handwashing procedure. Gloves should be part of the standard equipment that is carried by the home health aide. If the client has an infection, personal protective equipment should be provided by the home health agency.

Regulated medical waste is blood, blood products, sharp medical instruments, and dressings contaminated by body fluids. Personal items such as tampons, sanitary napkins, and razors are not considered medical waste. Each community has its own regulations for how this material should be handled. The supervisor will be able to describe disposal methods pertinent to the specific community in which the client resides. Standard precautions should be utilized for all home clients, just as with institutionalized clients. General guidelines for infection control are given in Figure 3.6.

The home health agency may have specific guidelines for infection control measures beyond the basic practices. The home health aide will need to be familiar with

Figure 3.6 - General Guidelines for Infection Control in the Home

- Cloth towels that are used by the client and others in the home will carry microorganisms and should not be used by the home health aide.
- Bar soap usually sits in soapy residue that can be a breeding ground for microorganisms, so liquid soap is preferable for handwashing.
- If running water is not available in the home, the home health aide should carry a waterless antiseptic agent to be used in place of the handwashing procedure.
- Gloves should be part of the standard equipment that is carried by the home health aide.
- If the client has an infection, personal protective equipment should be provided by the home health agency.
- Body waste products should be flushed down the toilet as soon as possible.
- Spills of body fluids or blood should be cleaned up by a person wearing gloves. The area should be wiped with a solution of one part household bleach to 10 parts water. The rag should be thrown out.
- Sharp objects such as needles should be placed in a puncture-resistant container. A coffee can with a plastic lid works well for this purpose. Some items may need to be disposed of immediately; others can accumulated until the can is full. Check with the supervisor to determine the procedure for disposal of such objects.
- Dressings should be placed in a plastic bag. If they are regulated medical waste, they must be double-bagged for disposal and/or transport.
- Unsoiled laundry does not need special attention. Soiled laundry should be handled with gloves and kept separate from the other laundry. If the soiled laundry cannot be cleaned immediately or must be transported out of the home, it should be double bagged in plastic. The contents of the double bags should be emptied into the washer without handling the items, and the plastic bags should be thrown away.
- If disinfectant solutions are needed to clean equipment, the cleaning solution should be disposed of by flushing it down the toilet.

the policies to protect both himself or herself and the client.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 3: Infection Control

Activity Sheet

1. What is a nosocomial infection?

2. Describe the four infectious diseases discussed in the lesson.
   a. HIV
   b. Hepatitis B
   c. Tuberculosis
   d. Pneumonia

3. What is a multidrug-resistant organism?

4. What are standard precautions?

5. Using standard precautions, when should hands be washed?

6. When should gloves be worn when using standard precautions?

7. According to standard precautions, when should personal protective equipment be used?

8. What is the standard precaution when transporting clients?

9. What should be done with soiled client care equipment according to standard precautions?

10. What are transmission-based precautions?

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11. Describe the types of transmission-based precautions.

    a. Airborne precautions ______________________________

    ____

    b. Droplet precautions ______________________________

    ____

    c. Contact precautions ______________________________

    ____

12. Identify four ways infection control is adapted to the home.

    a. ______________________________

    ____

    b. ______________________________

    ____

    c. ______________________________

    ____

    d. ______________________________

    ____

Clinical/Laboratory Activities

1. Practice donning and removing gloves, gowns, and masks as described for those procedures in the *Health Care Assistant Core* curriculum.

2. Identify which type of transmission-based precautions would be used in each of the following cases.

    a. The client has a form of influenza.

    ____

    b. The client has a greenish discharge from an arm wound.

    ____

c. The client has a cough.

____

d. The client has an itchy, red, draining rash over his or her arms and legs.

____

e. The client has tuberculosis.

____

Lesson 4:
Crisis Intervention

Objectives:

A. Identify types of crises a nurse assistant may encounter.

B. Describe crisis intervention techniques.

C. Use physical crisis intervention techniques.

D. Identify hazards to personal safety.

Key Terms:

- Crisis
- Developmental crisis
- Situational crisis
- Crisis intervention

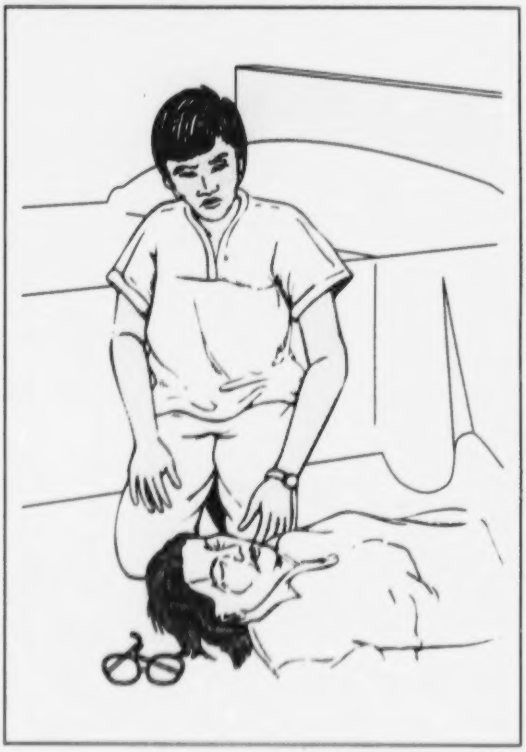
A **crisis** is a significant moment or event in a person's life or during an illness that has an emotional or physical effect on the individual. Even some happy events, such as weddings, can evolve into crises because they produce a great deal of stress. A crisis is usually of short duration, and the people involved use defense mechanisms (discussed in Unit III, Lesson 2) to relieve the stress of the situation. If a client is in crisis and cannot cope, unacceptable behavior may result. The health care worker must recognize the source of the behavior and intervene to resolve the crisis, if possible, and alleviate the stress.

Types of Crises

A crisis may be developmental in nature. A **developmental crisis** relates to a person's stage of life. People's lifestyles change as they age. With each change, new decisions must be made and different emotions managed. Examples of such changes are graduation from high school, marriage, and aging. A **situational crisis** may occur at any point in a person's life and is precipitated by an extremely stressful event. These crises are more common in health care, since they can be caused by illness, death, or a traumatic accident. Divorce or loss of a job may also cause a situational crisis.

While the nurse assistant may need to assist the client through a developmental crisis, situational crises that affect both the client and the nurse assistant may occur in any health care setting. Changes in physical condition; emergency situations, such as falls or burns (see Figure 4.1); ineffective coping behaviors; and even the personal safety of the nurse assistant can be crises. Each time the nurse

Figure 4.1 - Situational Crisis



assistant steps into a client's room, whether it be in a health care facility or in the home, a crisis may present itself.

Crisis Intervention

Crisis intervention is when a health care worker steps into a situation with the intent of resolving an immediate problem. The intent of the intervention is to decrease the stress produced by a sudden event and to identify resources to assist the client in coping with the situation. Since the person in crisis views the event as harmful or even life-threatening to him or her, the health care worker must be able to work quickly to resolve the crisis.

Crisis intervention is very similar to the problem-solving process. The first step is to ask, "What is wrong?" Is the problem physical, emotional, or the result of a combination of factors? If the crisis is an emergency, such as a fall, then the second step is to carry out emergency first aid measures and call for assistance. If the crisis is not an emergency, the nurse assistant should ask, "Do I have the necessary skills to handle the crisis, or do I need to contact my supervisor?" If the nurse assistant has the skills to handle the situation, the third step is to identify solutions to the problem. The client and others, such as family, should be consulted to collaborate in finding possible solutions. The best solution or combination of solutions can then be implemented for resolution of the crisis. In evaluating the solution, the behavior of the client should be observed to determine if the stress has been relieved. Figure 4.2 provides general tips for crisis intervention.

Hazards to Personal Safety

The crisis that confronts the nurse assistant may be one relating to his or her own personal safety. Health care workers encounter hazards to their personal safety because of their close interaction with the public. This includes not only the clients, but the clients' families and other visitors. If the nurse assistant is working in a hospital, people usually have unrestricted access to these facilities. The availability of drugs, needles, and other health care supplies in health care facilities, makes them a prime target for anyone seeking such substances. Health care workers also work late evenings, throughout the night, and during the early morning; usually with reduced staff during those hours. Health care workers, such as home health aides, may also work alone and in areas of high crime or rural isolation.

Sometimes, people who are ill lose their ability to cope with their situation and may exhibit violent behavior. Workplace violence ranges from offensive language to homicide. However, the most common personal safety hazards for the nurse assistant are hitting, kicking, pinching, scratching, and biting from a noncompliant

Figure 4.2 - General Tips for Crisis Intervention

- Avoid offering false reassurance by saying, "Everything will be all right." Such comments make clients feel less in control of their emotions.
- Assist clients to identify resources that may help with the situation.
- Assist clients to see what is factual and what is a false perception about the situation.
- Accept clients' emotions as normal reactions to the situation.
- Show acceptance and concern for clients.

client. Appropriate measures for dealing with an aggressive client were discussed in Unit III, Lesson 2.

The nurse assistant should always be alert to hazards to personal safety. Staying in areas with good lighting and avoiding threatening situations, such as stairwells or scarcely populated elevators, are some of the techniques to utilize when the nurse assistant is working alone, late at night, or in an area where there is potential danger. The buddy system can be used if another person is available so that neither person has to enter an area alone. If a situation appears threatening, immediately leave the area and request assistance. Most health care facilities will give a security escort to people who request them. If the nurse assistant is working alone in an area with a high crime rate or in an isolated rural area, a daily work plan should be on file. Clients should be instructed to call the agency if the home health aide does not show up as planned.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

After you have completed the activity sheets, you may take the written evaluation for this unit. A score of at least 80 percent indicates you may proceed to the next unit.

Lesson 4: Crisis Intervention

Activity Sheet

1. What is a crisis?

2. Differentiate between a developmental crisis and a situational crisis and give an example of each.

   a.

   b.

3. What is crisis intervention?

4. What are the steps taken to resolve a crisis?

   a. ____________________

   b. ____________________

   ____

   ____

   c. ____________________

   d. ____________________

   e. ____________________

5. List three reasons why health care workers experience hazards to their personal safety.

   a. ____________________

   ____

   b. ____________________

   ____

   c. ____________________

   ____

6. What are two things a health care worker can do to reduce potential personal safety hazards?

   a. ____________________

   ____

   b. ____________________

   ____

Clinical/Laboratory Activities

1. Identify any crises you have encountered in your life. Label them as developmental or situational crises and identify what you did to resolve them. Discuss them with the class.

2. Make a list of the hazards to your personal safety in coming to school, visiting a local shopping center, or visiting a movie theater. Identify what actions you would take to keep yourself safe. Discuss them with the class.

Unit Checklist

Student Name ______________________ Overall Unit Rating ________

Activity Sheet: Guidelines for Safety Rating ________

Comments: ______________________

Activity Sheet: Home Safety Issues Rating ________

Comments: ______________________

Activity Sheet: Infection Control Rating ________

Comments: ______________________

Activity Sheet: Crisis Intervention Rating ________

Comments: ______________________

Written Unit Evaluation Score ________

Additional Comments: ______________________

Teacher Signature ______________________ Date ________

Student Signature ______________________ Date ________

Unit V

Personal Care

Personal care includes all the activities that a person does to begin a new day. The activities become so routine to most people that they can do them without much thought. Most people prepare for the day by accomplishing tasks in a certain order. They get out of bed, walk to the bathroom, take care of elimination needs, shower, dress, brush teeth, and comb hair. Many clients are unable to tend to these needs on their own. The nurse assistant may have to encourage, assist, or complete the tasks for clients. We all like to leave home looking our best. Clients should be helped to look their best also.

Unit Lessons

Introduction to Personal Care

Eyeglasses, Hearing Aids and Prostheses

Dressing and Undressing

Bathing

Shaving

Hair Care

Oral Hygiene

Nail Care

Perineal Care

Backrub and Skin Care

Bedmaking

The Client's Environment

Lesson 1:
Introduction to Personal Care

Objectives:

A. Identify activities that make up personal care.

B. Discuss the general considerations in providing personal care.

C. Describe how to plan personal care activities.

D. Determine which clients require assistance with personal care activities.

E. Identify adaptive measures that may be necessary when giving personal care to clients with special conditions.

Key Terms:

- Personal care activities
- Activities of daily living
- Hemiparesis
- Paraplegia
- Quadriplegia
- Arthritis

Personal care is an important part of daily living. An individual's self-concept can be linked to how one thinks that he or she appears. Everyone wants to look their best when they see other people. Clients who can no longer do personal care for themselves do not lose the desire to look their best; thus, providing personal care measures will be a major part of the nurse assistant's activities.

Personal Care Activities

Personal care activities are activities that involve caring for the human body. These activities are a part of the **activities of daily living**, activities done on a daily basis as part of life. Individuals learn personal care activities as children and establish routines for accomplishing these activities. Personal care activities include assisting clients with the following: eyeglasses, hearing aids and prostheses; dressing and undressing; bathing; shaving; hair care; oral hygiene; nail care; perineal care; backrub and skin care; and applying cosmetics. Cosmetics should be applied according to the client's preferences using proper precautions and with consideration of the client's skin condition. Bedmaking is also included in personal care activities because having a clean, well-made bed contributes to cleanliness and good skin care. Since the environment surrounding the client contains personal items, maintaining this environment also becomes a part of personal care activities.

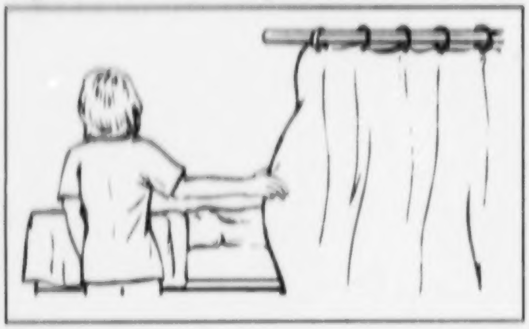
General Considerations in Providing Personal Care

Personal care helps the client to maintain a positive self-image and supports his or her good health. Each client will have unique needs. Some clients can do parts of their own personal care. Others cannot do any of it. The procedures for personal care activities are outlined throughout this unit. A client's preferences and circumstances may vary the order of the steps of a procedure. Personal care routines and preferences should be discussed with each client. Some clients may have a special way of doing an aspect of personal care; others may have certain times at which they prefer care to be completed. Clients should be encouraged to be as independent as possible, and to do as much of their personal care routine as their strength or ability allows.

The nurse assistant should wash his or her hands before and after any procedure. After greeting the client by name, the nurse assistant should introduce himself or herself to the client. Only the client's own personal care equipment should be used. Borrowing equipment, such as combs, lotion, and shavers, from another client can spread microorganisms from one client to another.

Provide a thorough explanation of the procedure. All nurse assistants should use good body mechanics and remember safety factors to protect themselves and the clients. Personal care should be done in private. As seen in Figure 1.1, respecting the client's privacy involves closing doors, pulling curtains, and not exposing the client during personal care procedures. If a personal care procedure requires the client to undress, provide warmth by covering as much of the body as possible, turning up the heat, and avoiding drafts. Clients may be very self-conscious about having personal care procedures done. The nurse assistant can reduce their embarrassment by being confident, matter-of-fact, and avoiding any verbal or nonverbal signs of distaste.

Figure 1.1 - Providing Privacy



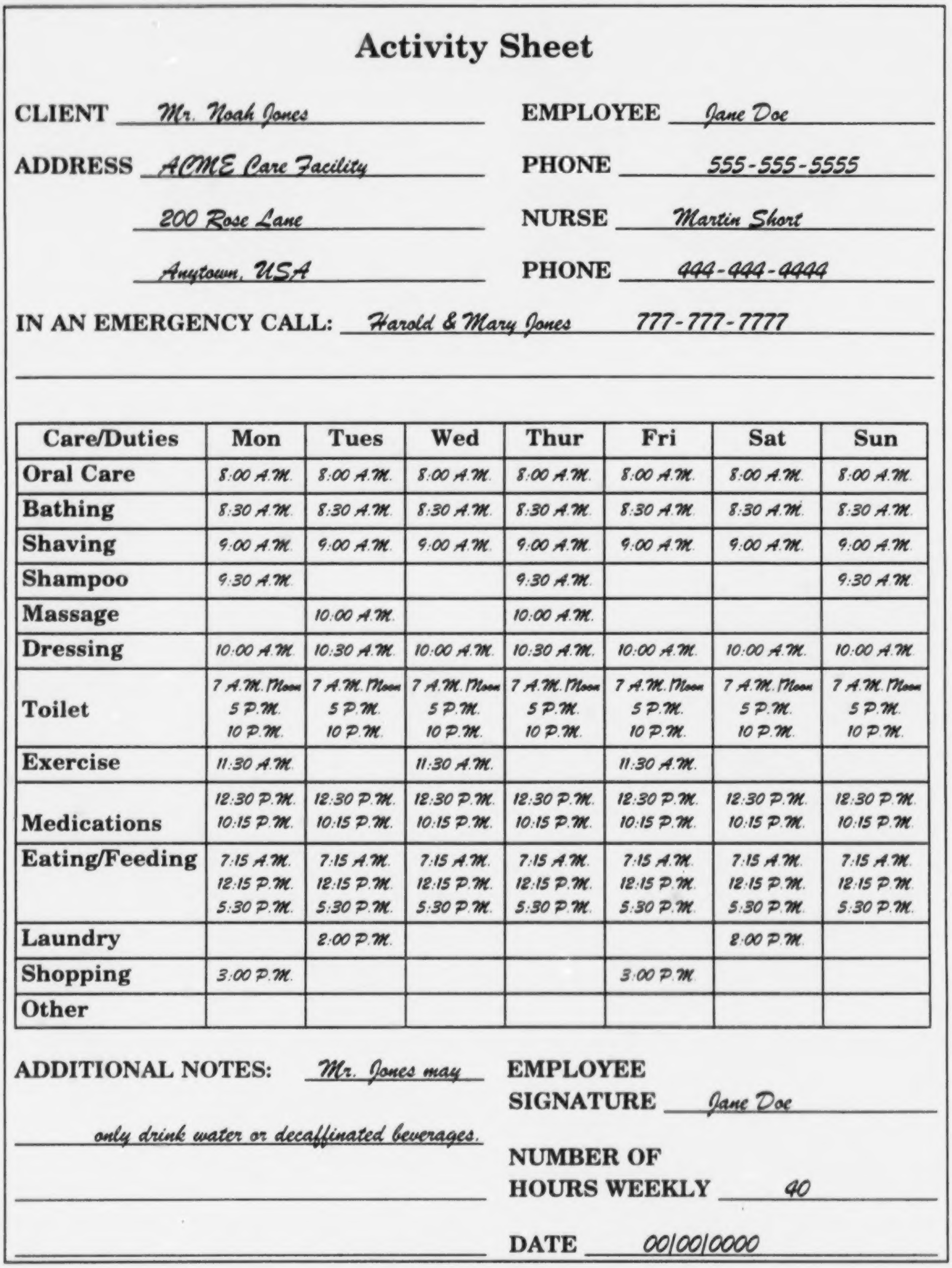
By communicating with clients while doing personal care activities, the nurse assistant can elicit a great deal of information about their physical and emotional condition. Personal care activities also present opportunities for making observations about the client by seeing, smelling, and touching. A pad and pencil should be kept nearby to record observations to report to the supervisor.

Planning Personal Care Activities

Planning requires knowing what the client can accomplish. The supervisor, other care givers, and the client's medical record can provide this information. Knowledge about the time required for a procedure comes with experience; however, the nurse assistant will need to be flexible as no one can predict the exact time needed. Clients will be slower and need more time on some days. Care planning must revolve around activities over which the nurse assistant has no control, such as mealtimes and therapy sessions. Before planning, the nurse assistant should use a written list of all activities and a tentative schedule as shown in Figure 1.2. Care plans for home health clients are made according to the routine that best suits clients' needs. The home health aide may have specific appointment times for each client during the day. If the agency does not provide the home health aide with a set schedule, he or she should contact clients before visiting to set times that best suit their needs. In planning home health visits, the home health aide must consider driving time to develop a schedule that meets clients' needs and limits mileage.

To save time, gather needed supplies before the personal care procedure. Sometimes supplies can be distributed to several clients at once. For example, when

Figure 1.2 - Tentative Activity Sheet



Activity Sheet

CLIENT Mr. Noah Jones

EMPLOYEE Jane Doe

ADDRESS ACME Care Facility
200 Rose Lane
Anytown, USA

PHONE 555-555-5555

NURSE Martin Short

PHONE 444-444-4444

IN AN EMERGENCY CALL: Harold & Mary Jones 777-777-7777

Care/Duties	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Oral Care	8:00 A.M.	8:00 A.M.	8:00 A.M.	8:00 A.M.	8:00 A.M.	8:00 A.M.	8:00 A.M.
Bathing	8:30 A.M.	8:30 A.M.	8:30 A.M.	8:30 A.M.	8:30 A.M.	8:30 A.M.	8:30 A.M.
Shaving	9:00 A.M.	9:00 A.M.	9:00 A.M.	9:00 A.M.	9:00 A.M.	9:00 A.M.	9:00 A.M.
Shampoo	9:30 A.M.			9:30 A.M.			9:30 A.M.
Massage		10:00 A.M.		10:00 A.M.			
Dressing	10:00 A.M.	10:30 A.M.	10:00 A.M.	10:30 A.M.	10:00 A.M.	10:00 A.M.	10:00 A.M.
Toilet	7 A.M. Noon 5 P.M. 10 P.M.	7 A.M. Noon 5 P.M. 10 P.M.	7 A.M. Noon 5 P.M. 10 P.M.	7 A.M. Noon 5 P.M. 10 P.M.	7 A.M. Noon 5 P.M. 10 P.M.	7 A.M. Noon 5 P.M. 10 P.M.	7 A.M. Noon 5 P.M. 10 P.M.
Exercise	11:30 A.M.		11:30 A.M.		11:30 A.M.		
Medications	12:30 P.M. 10:15 P.M.	12:30 P.M. 10:15 P.M.	12:30 P.M. 10:15 P.M.	12:30 P.M. 10:15 P.M.	12:30 P.M. 10:15 P.M.	12:30 P.M. 10:15 P.M.	12:30 P.M. 10:15 P.M.
Eating/Feeding	7:15 A.M. 12:15 P.M. 5:30 P.M.	7:15 A.M. 12:15 P.M. 5:30 P.M.	7:15 A.M. 12:15 P.M. 5:30 P.M.	7:15 A.M. 12:15 P.M. 5:30 P.M.	7:15 A.M. 12:15 P.M. 5:30 P.M.	7:15 A.M. 12:15 P.M. 5:30 P.M.	7:15 A.M. 12:15 P.M. 5:30 P.M.
Laundry		2:00 P.M.				2:00 P.M.	
Shopping	3:00 P.M.				3:00 P.M.		
Other							

ADDITIONAL NOTES: Mr. Jones may only drink water or decaffinated beverages.

EMPLOYEE SIGNATURE Jane Doe

NUMBER OF HOURS WEEKLY 40

DATE 00/00/0000

making six beds, distribute the linen for all the beds before making any of them. Placing equipment and supplies easily within reach will save both time and energy. After the procedure, equipment and supplies should be cleaned and put away to insure easy access for the next time or for the next person who may complete the procedure.

Determining Which Clients Need Assistance with Personal Care

The nurse assistant may be told which clients require assistance and which clients are independent in all or part of the personal care activities. If the nurse assistant does not receive this information, he or she can observe clients to determine how much assistance is needed. Those clients who are unconscious or unaware of their own needs will require complete assistance. Clients who are on bed rest will be limited in what they can do. Some may feel like washing their own faces and upper bodies and combing their own hair; others may require total assistance due to weakness. The nurse assistant should carefully observe clients who have requested to do their own personal care. A client may not realize the extent of his or her weakness and may require the nurse assistant to step in to complete the task. Clients with physical limitations, such as a paralyzed arm and/or leg, or an extremity that is in a cast, may require assistance until they learn to adapt to their limitations. A client's ability to do activities of daily living can change from day to day. The nurse assistant should not rely on previous contact with the client to determine how much assistance he or she may need. Extensive therapy or diagnostic examinations may have depleted the client's strength so that he or she needs to have more assistance. Extensive vomiting, diarrhea, or other temporary conditions may also cause a client to require assistance. Clients may not have specific complaints but may lack the necessary strength or motivation to do personal care activities on their own. Using good observation skills, nursing experience, and intuition will help the nurse assistant to know when to push clients to do activities on their own and when to provide assistance.

Adaptive Measures for Special Conditions

Unconscious clients cannot respond during personal care activities. Explanations should be given about what is being done by talking to unconscious clients as if they can hear and respond. The nurse assistant may need help when lifting and moving these clients since they cannot assist in any way. The client's body should be kept in proper alignment during all procedures. Position the client correctly when personal care is completed. The side position is usually best because an unconscious client can choke on or aspirate his or her own saliva. Care of the skin and perineal area is a primary concern if incontinence is present.

Clients may experience **hemiparesis**, the paralysis of one side of the body, either the right or left, that can occur with a stroke. **Paraplegia** is paralysis of the lower extremities, and **quadriplegia** is paralysis of all four extremities. When helping a client experiencing paralysis, the nurse assistant should handle the affected side or extremities with care, supporting the affected joints. Position affected extremities to maintain good circulation and so that the client is not lying on affected limbs. Avoid using the terms "good side" and "bad side" when giving care. The recently paralyzed client may be undergoing extensive physical and occupational therapy to regain as much mobility as possible. The nurse assistant should use the techniques being taught to the client for self-care in any personal care activities. A client who has been paralyzed for some time may have developed unique routines for completing personal care independently. The nurse assistant should be supportive in assisting with those routines.

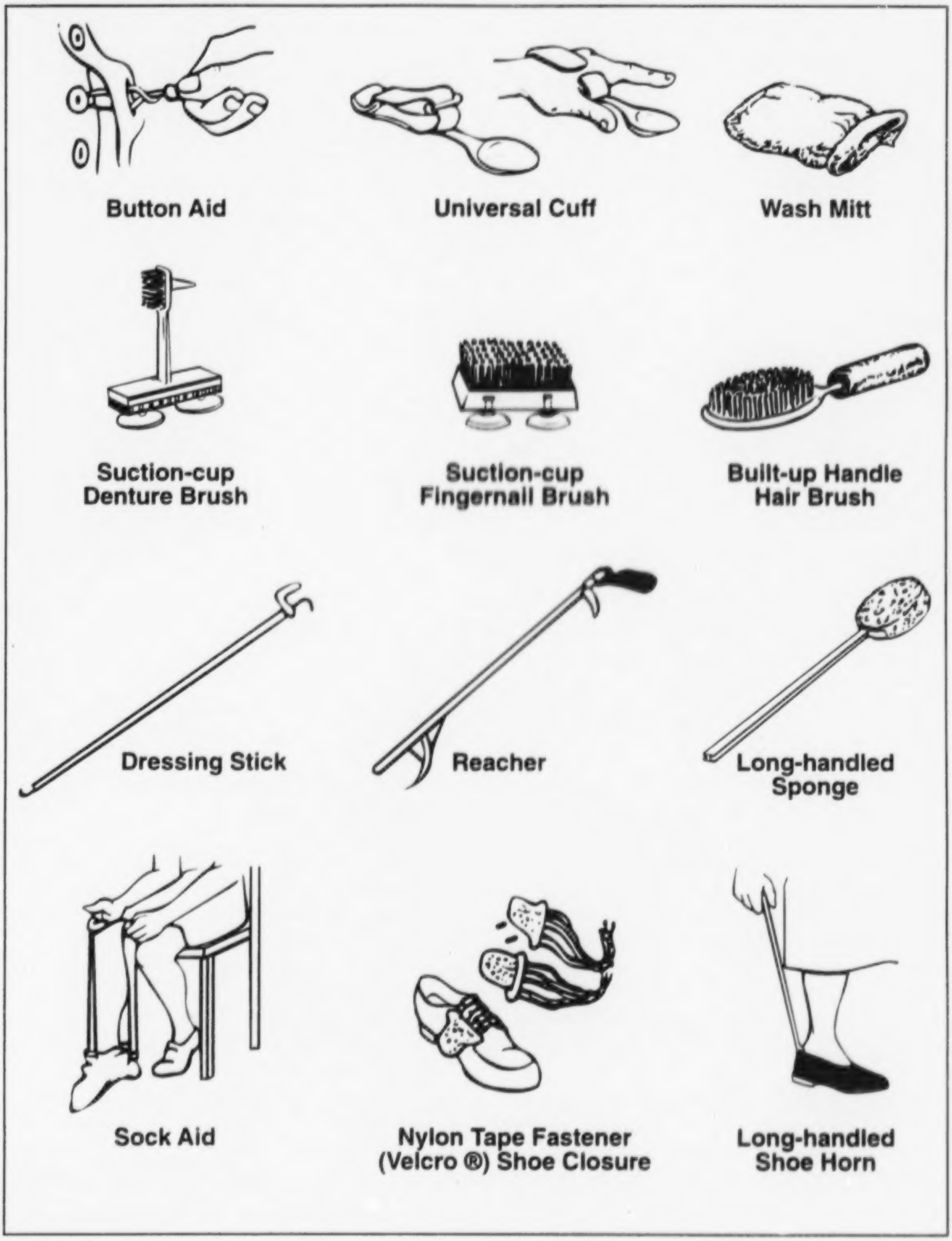
Skin care is extremely important for clients with diabetes, as they have poor circulation and their wounds heal slowly. The skin must be kept very clean and observed for breakdown, lesions, or tears. The nurse assistant should report any blemish or disruption of the integrity of the skin to the supervisor. Clothes and shoes should be checked to make sure they do not impair the circulation or rub the skin. Feet and legs are particularly susceptible to poor circulation and should be checked thoroughly for any changes. Clients with diabetes are susceptible to loss of sensation from nerve endings, and they may not feel any pain from wounds or infections. Refer to the *Health Care Assistant Core* curriculum for additional information on diabetes.

Arthritis is an inflammation of a joint. It is one of the most common chronic health conditions to affect the elderly. Although the joint is painful, exercise keeps the joint mobile and may even contribute to reducing swelling and pain. Clients with arthritis may need to be encouraged to participate in personal care activities and may need more time to complete activities. If the arthritis has been present for a long time, joints may already be inflexible, making it difficult to dress, undress, or move the client. Any joint affected by arthritis should not be forced beyond its range of motion. Clients with arthritis may be more easily exhausted, so personal care activities should be arranged to allow for periods of activity alternated with periods of rest. The nurse assistant should understand that the pain of the disorder may cause a client to be quite irritable. Clients may need to use adaptive devices, such as built-up handles on toothbrushes, button hooks, a dressing stick and elastic shoelaces to perform personal care activities independently. (See Figure 1.3)

Pain influences a client's ability to do personal care activities. Pain may be caused by many diseases and treatments and is experienced differently by different people. Not every client will admit to having pain. Signs of pain may include a rapid pulse; shallow and rapid breathing; fatigue; high anxiety; crying and moaning; grimacing; holding the body still; and being non-communicative. If the client verbalizes pain or shows signs of pain, delay personal care activities until the client has been given or has taken pain medication. Clients experiencing pain may need complete assistance with personal care although they may do their own care when they are not experiencing pain. Distracting clients from the pain by conversing with them during personal care activities may help. A client in pain should not be rushed; procedures should be done at a pace that does not increase the pain. Rest periods may be incorporated into the personal care activities. Notify the supervisor if medication does not relieve the client's pain, or if the client cannot complete personal care independently or with assistance.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Figure 1.3 - Adaptive Devices



Button Aid

Universal Cuff

Wash Mitt

Suction-cup Denture Brush

Suction-cup Fingernail Brush

Built-up Handle Hair Brush

Dressing Stick

Reacher

Long-handled Sponge

Sock Aid

Nylon Tape Fastener (Velcro ®) Shoe Closure

Long-handled Shoe Horn

Lesson 1: Introduction to Personal Care

Activity Sheet

1. Identify five activities that make up personal care.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

   e. ______________________________

2. What is the difference between personal care activities and activities of daily living?

   a. Personal care activities - ______________________________

   ____

   b. Activities of daily living - ______________________________

   ____

3. Personal care helps the client in what two ways?

   a. ______________________________

   b. ______________________________

4. Identify six general considerations when providing personal care.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

   e. ______________________________

   f. ______________________________

5. Identify four factors that should be considered when planning personal care activities.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

6. What are two ways to determine which clients need assistance with personal care?

   a. ______________________________

   b. ______________________________

7. Identify two considerations when providing personal care for each of the following clients:

   a. Client who is unconscious

      1. ______________________________

      2. ______________________________

   b. Client with paralysis

      1. ______________________________

      2. ______________________________

   c. Client who has diabetes

      1. ______________________________

      2. ______________________________

   d. Client who has arthritis

      1. ______________________________

      2. ______________________________

   e. Client experiencing pain

      1. ______________________________

      2. ______________________________

Clinical/Laboratory Activities

1. List all the activities that you do before you leave the house for school or work each morning. Which ones are personal care activities, and which ones would better fit under the broader category of activities of daily living?

2. Working in groups of three or four, identify any special considerations you would like in your own personal care routine if someone else had to do it for you. What are the common ones that all would like to have done?

3. Using the list of personal care activities given in this lesson, create a schedule for the personal care of one resident who cannot assist you and one for a resident who can partially assist you. Put the activities in the order you feel would be best to accomplish them. Include how much time in minutes that you feel it would take to accomplish the task. Meet in your group and compare schedules. Use a group consensus to develop a master schedule for each type of client.

4. Find a family member, friend, neighbor, or acquaintance who has a special condition identified in this lesson. Talk with him or her about the adaptations he or she has made in his or her personal care routine. Compare your findings with those of others in a class discussion.

Lesson 2:
Eyeglasses, Hearing Aids and Protheses

Objectives:

A. Describe types of hearing aids.

B. Maintain hearing aids.

C. Insert and remove a hearing aid.

D. Maintain eyeglasses.

E. Place and remove eyeglasses.

F. Describe types of prostheses and their proper care.

Key Terms:

- Intraauricular aids
- Behind-the-ear aids
- Eyeglass aids
- Body-worn aids
- Prosthesis

Many people require aids to manage sensory deficits or prosthetic devices to replace body parts. Each item becomes a part of the person and is included in the personal care routine.

Types of Hearing Aids

There are four types of hearing aids. **Intrauricular aids** are worn in the ear. **Behind-the-ear aids** have a piece that fits in the ear with a channel that connects to a piece placed behind the ear. **Eyeglass aids** attach to the earpiece of a pair of eyeglasses. **Body-worn aids** have a piece placed in the ear connected by a cord to the sound amplifier that looks like a small radio or cassette recorder. The amplifier is placed in a pocket or clipped on a belt. All four types contain an earmold, an amplifier, batteries, a volume control, and a power switch as shown in Figure 2.1.

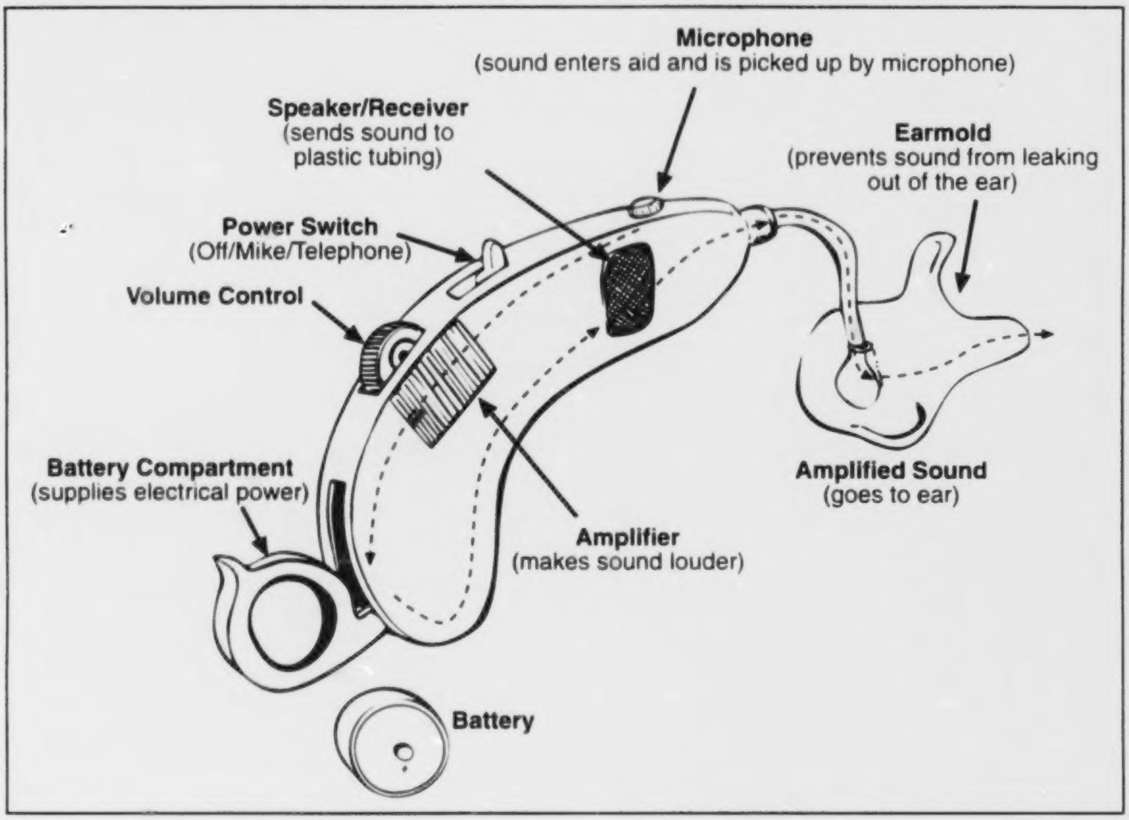
Wearing a hearing aid takes adjustment. Hearing aids are usually worn only for a short time at first. Wearing time increases on a daily basis until an aid is worn for the complete day. The hearing aid amplifies all sound, not just voices. Clients who wear hearing aids may be distracted in a busy, noisy environment; they may require a quieter place for good communication. The hearing aid does not affect the clarity of sounds and voices; they simply make sounds and voices louder. If the nurse assistant mumbles or uses unclear communication, the hearing aid will not improve the client's ability to understand what he or she is saying. Hearing aids should be removed before bathing and sleeping.

The ear canal should be examined every day before inserting the hearing aid. The supervisor must be notified if irritation, redness, swelling, pain, or drainage is present.

Care, Maintenance and Cleaning of Hearing Aids

Hearing aids are expensive pieces of equipment. Proper care, maintenance, and cleaning of the aids will help prolong the life of the equipment. Hearing aids work on battery power. The battery should be inserted correctly with the positive and negative signs on the battery matching those on the hearing aid. A battery will last approximately 10-14 days. To check batteries, turn the volume control on fully. When this is done, the hearing aid will whistle or squeal if it has power. When

Figure 2.1 - Parts of a Hearing Aid


Microphone
(sound enters aid and is picked up by microphone)
Speaker/Receiver
(sends sound to plastic tubing)
Earmold
(prevents sound from leaking out of the ear)
Power Switch
(Off/Mike/Telephone)
Volume Control
Battery Compartment
(supplies electrical power)
Amplified Sound
(goes to ear)
Amplifier
(makes sound louder)
Battery

the hearing aid is not in the ear, it should be turned off. If the hearing aid does not have an on/off switch, the battery should be removed to conserve power. Extra batteries should be stored in a cool, dry place.

All parts of the hearing aid should be wiped daily with a clean, slightly damp cloth. The earmolds of all hearing aids, except the intrauricular aids, can usually be removed. If the earmold gets very dirty, it should be removed from the rest of the aid and washed with mild soap and water. If the earmold is plugged with wax, it should be carefully removed from the hole with a toothpick, pipe cleaner, or a special wax-removing tool. The earmold should be dried thoroughly, preferably overnight, and air blown through the opening before reattaching it back on the aid. *The earmold is the only piece of the hearing aid that can be washed and then only if it can be detached from the rest of the hearing aid.* Cleaning agents such as alcohol should NOT be used when cleaning hearing aids.

The hearing aid should be kept away from excessive heat and cold. The heat of a blowdryer may damage the hearing aid mechanism, along with very hot, humid or very cold weather. Hair sprays, hair lotions, spray perfumes, and shaving lotions may also damage the hearing aid. The hearing aid should be placed in the ear after personal care is completed or protect the hearing aid if liquids or sprays are being used near the ear. Sharp objects should NOT be inserted into any opening of the hearing aid other than the earmold. The nurse assistant should be careful not to drop the hearing aid on a hard surface. When changing the batteries or cleaning the device, the nurse assistant should hold the hearing aid over the bed or another soft surface. If the hearing aid is not going to be used for several days, the battery is removed to prevent potential corrosion from damaging the case. Twisting or bending any tubing or wires should be avoided.

Steps of Procedure for Inserting or Removing a Hearing Aid

Inserting a Hearing Aid:

1. Wash your hands.
2. Make sure the hearing aid is turned off and the volume is in the lowest position.
3. Determine if the hearing aid is for the right or left ear.
4. Line up the parts of the earmold with the corresponding part of the external ear.
5. Insert the earmold into the external canal of the ear.
6. Gently push the earmold into the ear canal while rotating it slightly toward the back of the ear until the earmold fits snugly and comfortably into the canal.
7. Adjust the other parts of the hearing aid:
    a. Position the battery holder and amplifier portion of a behind-the-ear aid with the tubing over the top of the ear and the rest behind the ear against the skull.
    b. Position the battery holder and amplifier portion of a body-worn aid in a pocket or carrier, or clip it to the clothing or a belt with the cord lying smoothly along the neck.
8. Turn the hearing aid on. If the hearing aid whistles, the earmold may not be inserted correctly and should be removed. Steps 4 to 7 need to be repeated.
9. Slowly turn the volume up, at least halfway, and adjust as the client requests.

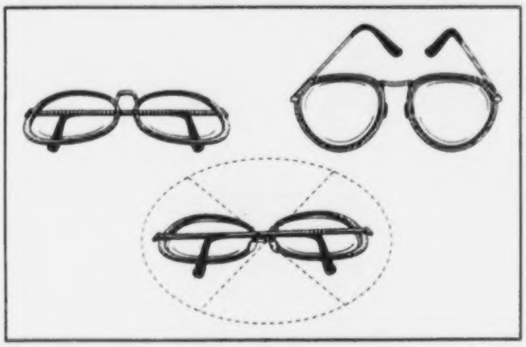
Removing a Hearing Aid:

1. Turn the hearing aid off and lower the volume to the lowest position.
2. Grasp the earmold, rotating it toward the front of the ear, while pulling it outward.
3. When the earmold is out of the ear, unhook or unclip other parts of the hearing aid.
4. Store the hearing aid in a case or safe place.

Maintaining Eyeglasses

Eyeglasses are used to correct visual deficits. Misperceptions and even behavioral problems can occur when the client cannot see adequately. Today, most eyeglass lenses are made of a plastic material to lighten the weight of the glasses. It is almost impossible to tell whether the lenses are plastic or glass so treat all lenses as if they are plastic and are easily scratched. Glasses should be handled by the frames. When not in use, glasses should be placed in a case. If a case is not available, glasses can be placed on the folded earpieces or on the frame, but NEVER on the lenses as seen in Figure 2.2. Glasses should be cleaned daily with either a mild soap and water or a special eyeglass-cleaning solution. Alcohol should NOT be used to clean either the lenses or the frames. Glasses should be dried with a clean, soft cloth, NOT with tissues and paper towels as these items are made of paper containing wood fragments that may scratch plastic lenses. Eyeglasses should NOT be wrapped in tissues, washcloths, towels, or other linens that may be disposed of accidentally.

Figure 2.2 - Placement of Eyeglasses



Steps of Procedure for Placing and Removing Eyeglasses

Placement of Eyeglasses:

1. Wash your hands.
2. Open the ear pieces of the glasses.
3. Clean the glasses using soap and water or an eyeglass-cleaning solution.
4. Dry the glasses using a clean, soft cloth.
5. Hold the glasses by the corners of the frames.
6. Guide the earpieces over the top of both ears.
7. Push the lens frame to the top of the bridge of the nose.
8. Check with the client to make sure the glasses are positioned comfortably.

Removal of Eyeglasses:

1. Grasp the eyeglasses by the corners of the frames.
2. Pull the glasses down along the bridge of the nose until the earpieces clear the tops of the ears.
3. When the earpieces have cleared the tops of the ears, pull the glasses straight out away from the face.
4. Fold the earpieces down.
5. Place in an eyeglass case or in a safe place with the lens turned up.

Types of Prostheses and Their Care

A **prosthesis** is an artificial device used to replace a missing part of the body. The most common prosthesis is a limb, either an arm or leg, or part of those extremities. Some are very simple, made out of a plastic substance with a simple hinge joint. Others may be complex electronic devices that function similar to the client's own natural extremities. Most require a combination of straps and buckles to hold the device in place. If the prosthesis needs cleaning, a soft, damp cloth can be used to wipe the device. Substances that could stain or mark the device, such as indelible pens, bleach, and paint, should be avoided. A removed prosthesis should be placed safely in the closet or drawer. When it is not in use, the socket of the prosthesis should be cleaned (if needed) and dried before being put away. The skin on the stump of the extremity should be observed for redness or irritation before applying or after removing a prosthesis. Each device is fitted specifically for the client and each has its unique way of being applied. If the client or a family member is unable to help with the application of the device, the nurse assistant should contact the supervisor for assistance.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 2: Eyeglasses, Hearing Aids and Prostheses

Activity Sheet

1. List and describe the four different types of hearing aids.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

2. What are two considerations for maintaining hearing aid batteries?

   a. ______________________________

   b. ______________________________

3. How is a hearing aid kept clean? ______________________________

   ____

4. List four considerations regarding the general care of the hearing aid.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

5. How should eyeglasses be handled? ______________________________

   ____

   ____

6. What should be used to clean eyeglasses? ______________________________

   ____

   ____

7. How should a prosthesis be cleaned? ______________________________

8. What should be avoided around a prosthesis? ______________________________

9. What observations should you make before applying or after removing a prosthesis?

10. What should you do if you do not know how to apply the prosthesis and the client and family cannot help you?

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedures for placing and removing hearing aids and eyeglasses, practice the activities with a partner in the laboratory. A pair of sunglasses may be used.

2. If the instructor has sample hearing aids available, examine the parts and practice inserting and removing the batteries.

3. Find someone in your family or among your acquaintances who has a hearing aid. Discuss problems that he or she might have had in adjusting to the hearing aid. Find out how he or she cares for the aid and any tips that he or she may have for working with a client with a hearing aid. Share your findings with the class.

Lesson 3:
Dressing and Undressing

Objectives:

A. Discuss the general considerations when dressing and undressing clients.

B. Assist clients to dress.

C. Assist clients to undress.

Key Term:

- Lap robe

Wearing appropriate, clean, and neat clothing is an essential part of good grooming. In long-term care, acute care and home health settings, nurse assistants and home health aides are frequently responsible for assisting with or dressing and undressing clients. The following lesson refers to the ways nurse assistants can aid clients in this personal care activity.

General Considerations in Dressing and Undressing Clients

Being appropriately dressed gives the client a sense of identity and enhances his or her self-image. Because of illness and disability, clients may not be able to dress or undress independently, however clients should be allowed to do as much as possible for themselves. If it appears that the client has difficulty dressing or undressing, the nurse assistant should ask if help is needed. When assisting a client, the nurse assistant should ask if the client has a preferred way of putting on or removing a garment. Clients may have special methods of dressing themselves, such as putting on slips inside out to prevent them from "crawling up" inside dresses or leaving certain buttons unbuttoned. These techniques should be accommodated if the client is dressed appropriately. Adapted clothing with front fasteners or nylon tape fastenings instead of buttons, snaps, and zippers can promote independence for clients with disabilities. A client's clothing may not be altered without the permission of the client or family.

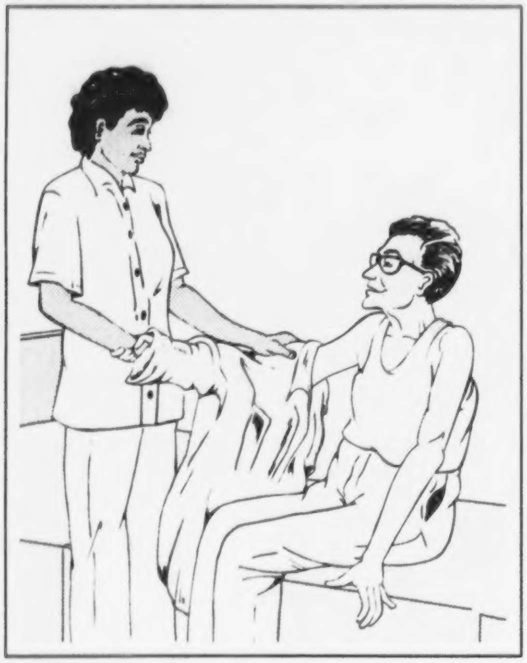
Allow clients to choose their own clothing. Provide clients who have difficulty making decisions with a choice between two different outfits. Most clients can be assisted or taught how to put on regular clothing for day and night wear. Clothing worn during the day should be different from clothing worn at night to help clients who are confused about time. Some clients may need suggestions to insure proper dress for a season or for different occasions. The elderly and those who are very frail from illness may be more sensitive to the cold than other persons; they should be dressed warmly. Clients who use wheelchairs may need **lap robes**, small blankets that fit over the lap. These provide warmth and prevent exposure.

Clothing should be in good repair, not ripped or torn, which may present a hazard to the client or cause embarrassment from exposure. Personal clothing of clients in long-term care facilities should be labeled with each client's name in permanent ink. The name should not be marked where it will show when the garment is worn. Clients should put on clean clothing after bathing and any time clothing becomes soiled. The families of clients in acute care are responsible for the clients' personal laundry and should provide proper containers for soiled articles to be placed in and picked up. Family members or facility personnel may do the laundry of clients residing in long-term care facilities. If the family does the laundry, a notice will be posted in the client's room that the family is responsible for the client's personal laundry. The family must provide a container in which to place soiled articles until they can be picked up. If the family does not do the client's personal laundry, it is placed in the facility's laundry or where designated by the facility. Home health aides must determine from the family where to place soiled articles of clothing.

Assisting a Client to Dress

The client should be exposed as little as possible during dressing or undressing. This prevents embarrassment and keeps the client as warm as possible. The weak or non-functioning side of a client with paralysis is dressed first. To conserve the energy of very weak clients, put on underclothes, stockings or socks, and slacks while the client is still lying down. Clients who need total assistance can be completely dressed in bed before being transferred to a chair. The easiest position for dressing or undressing a client who can help is sitting on the edge of the bed as seen in Figure 3.1. Avoid dressing clients in tight or constrictive clothing to prevent hindering circulation. Clients who wear stockings that support circulation should have these put on before the client sits up or gets out of bed. Shoes should be placed on the client's feet before the client stands up to prevent slipping and falling. The following lists the steps for assisting a client to dress.

Figure 3.1 - Assisting a Client to Dress



Steps of Procedure for Assisting a Client to Dress

1. Wash your hands.
2. Identify and greet the client.
3. Identify self.
4. Explain what you are going to do.
5. Confer with the client to decide articles of clothing to be worn.
6. Assemble necessary clothing and adaptive devices.
7. Provide privacy.
8. Assist the client in removing clothing currently being worn.
9. Brassiere
    a. Place around the chest with fasteners in front.
    b. Fasten the bra.
    c. If the bra is a back-hook bra, shift it so fasteners are in back.
    d. Have client slip arms through the shoulder straps.
    e. Adjust cups to enclose breasts or assist the client to do so.
10. Undershirt/slip/dress/shirt/sweater (over the head)
    a. Have client place arms into appropriate holes or assist the client to do so.
    b. Assist or have client put head into appropriate opening.

   c. Pull garment down into place over the client's shoulders, smoothing it in place down the client's back.
11. Stockings/socks
    a. Roll the stocking/sock down to the toes.
    b. Support the client's ankle and slip the rolled stocking/sock over the toes.
    c. Smooth the stocking/sock over the heel, making sure there are no wrinkles.
    d. With one arm on each side of the client's leg, pull the stocking/sock up over the leg.
    e. Complete the same procedure with the other stocking/sock.
12. Underpants/slacks/pants
    a. Place both feet through the openings for the legs.
    b. Slide the garment up as far as the client's position allows.
    c. If the client is lying down and can raise the hips, have him or her do so and pull the garment up over the hips. If the client is unable to lift the hips, turn the client first to one side then the other while pulling the garment up on each side.
    d. If the client can stand, he or she should do so with the garment pulled into place over the hips.
    e. Fasten the garment if necessary. If a male client has a catheter, leave the fly of the slacks unzipped to allow the tubing to pass through, and then pin the fly closed.
13. Shoes
    a. Loosen laces and pull tongue of the shoes forward and up.
    b. Support the client's ankle while sliding the shoe onto the toes.
    c. With your hand on the bottom of the shoe to provide pressure, ease the shoe onto the heel. Using a shoehorn will ease the procedure for tight, supportive shoes.
    d. Have the client stand down on the shoe to force the foot completely into position.
    e. Tie shoelaces if needed.
14. Dress/shirt that buttons down the front
    a. Place the weakest arm in a sleeve first.
    b. Bring the shirt around the back of the client.
    c. The remaining arm can either be lifted over the head to be placed in the armhole or held down and to the side with the arm bent back at the elbow.
    d. Assist with buttons or zippers as needed.
15. Assist the client to put on accessories, such as suspenders, belts, scarves, or jewelry.
16. Collect removed garments and put them in the appropriate receptacle. Put clean clothing in the closet or dresser and soiled linen and dirty clothing in a hamper.
17. Make the client comfortable in an acceptable position or assist to the desired activity.
18. Wash your hands.
19. Record any pertinent observations and report unusual occurrences to the supervisor.

Assisting a Client to Undress

When undressing a client, the nurse assistant should expose the client as little as possible to prevent embarassment and to keep the client warm. Also, a weak or nonfunctioning side of a client should be undressed last. The following procedure lists the steps for assisting a client to undress.

Steps of Procedure for Assisting a Client to Undress

1. Wash your hands.
2. Identify and greet the client.

3. Identify self.
4. Explain what you are going to do.
5. Determine appropriate clothing to be put on after current garments are removed.
6. Assemble necessary articles of clothing and adaptive devices.
7. Provide privacy.
8. Assist the client to sit on the side of the bed if strength permits or to lie down if he or she is feeling weak.
9. Remove shoes.
   a. Loosen shoelaces and pull tongue up and away from the foot.
   b. Support the ankle with one hand and place other hand around the heel of the shoe.
   c. Pull the shoe away from the heel.
   d. When the shoe is free of the heel, pull the shoe up and off toes.
   e. Place shoes in closet or underneath bed where the client will not trip over them.
10. Remove stockings/socks.
   a. Roll stocking/sock down to the ankle.
   b. Support the ankle with one hand while pulling stocking/sock down over the heel with the other hand.
   c. Slide stocking/sock up over toes.
11. Undershirt/slip/dress/shirt/sweater (over the head)
   a. Loosen all fastenings
   b. Grasp bottom of the garment at the back
   c. Pull the garment up to the back of the client's neck.
   d. Pull the garment over the client's head from the back to the front.
   e. Pull the garment down over the client's arms.
12. Dress/shirt that buttons up the front
   a. Loosen all fastenings.
   b. Remove the garment from the stronger side by sliding the sleeve down the client's arm and toward the back of the body.
   c. Pull the garment across the back.
   d. Slide the garment off the weaker arm.
13. Slacks/pants/underpants
   a. Loosen all fastenings.
   b. If the client is able, the garment should be slipped down the legs while the client is standing.
   c. If the client is unable to remain standing but can raise the hips from a lying position, the garment can be slipped down over the hips while the client raises up.
   d. If the client cannot raise hips from a lying position, roll the client to one side and slip the garment over that hip, then roll the client to the other side and repeat the procedure.
   e. Slide the garment down the client's legs and off the feet.
14. Brassiere
   a. Unfasten bra.
   b. Slip straps down arms.
   c. Pull the garment away from body and the straps off the arms.
15. Collect garments removed and place them in appropriate receptacles.
16. Make the client comfortable.
17. If the client has been undressed and put to bed for the night, place the call device within reach.
18. Wash your hands.
19. Record pertinent observations and report unusual occurrences to the supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 3: Dressing and Undressing

Activity Sheet

1. Why should the client be dressed appropriately? ______________________________

2. What should you do if the client has difficulty choosing what clothing to wear?

3. Identify where personal laundry goes in acute, long-term, and home health care.

   a. Acute care ______________________________

   b. Long-term care ______________________________

   c. Home health care ______________________________

4. What changes should be made in the dressing/undressing routine for the following clients?

   a. Client with a weak or paralyzed side of the body

   ____

   ____

   b. Client who is very weak

   ____

   ____

   c. Client who needs total assistance

   ____

   ____

   d. Client with stockings that support circulation

   ____

   ____

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedures for dressing and undressing clients, practice the activities with a partner in the laboratory.

   a. First, role-play one partner being a client with a weak side of the body, then the other partner assuming the client's role.

   b. Practice dressing and undressing the partner with each type of garment included in the procedure.

Lesson 4:
Bathing

Objectives:

A. Identify the purposes of bathing.

B. Identify and differentiate types of baths.

C. Discuss general considerations for bathing.

D. Describe safety measures needed during bathing.

E. Discuss adaptations for giving or assisting with a bath in the home.

F. Give a complete bed bath.

G. Give a tub bath.

H. Give a whirlpool tub bath.

I. Give a shower bath.

Key Terms:

- Complete bed bath
- Partial bed bath
- Tub bath
- Whirlpool tub bath
- Shower bath

Bathing is a very personal activity which has many forms. People in a hurry can take quick showers. A long, leisurely soak in a bubble bath may help a person relax. A session in a whirlpool can be stimulating. The client's health and/or abilities will determine the type of bathing to be used. The nurse assistant must be knowledgeable about types of bathing to meet the personal care needs of clients.

Purposes of Bathing

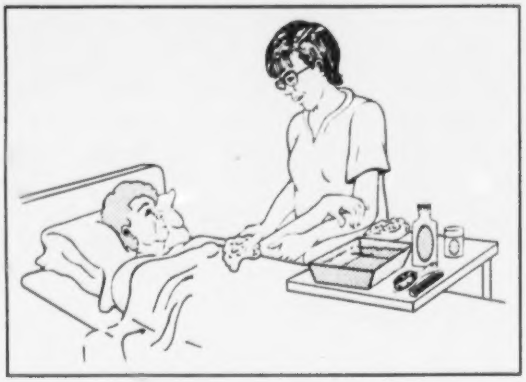
One purpose of bathing is to promote cleanliness and comfort. In promoting cleanliness, bathing can be done to the complete body or a specific part of the body, such as the perineal area when a client is incontinent. Bathing with soap and water, or even just water, removes waste products excreted by the skin and dust and dirt accumulated on the skin during activities of daily living. The warmth of the water and the rubbing of the skin with a washcloth stimulates circulation. Also, removing the top layer of dead skin cells stimulates the skin. A bath can assist in keeping muscles functional because it requires a degree of body movement. A bath may also be used for cooling the body, such as during a high fever. Submerging the body in a tub of tepid water or sponging with tepid water allows the water to evaporate and cool the body. Since the body is exposed during a bath, the nurse assistant can use bathing as an opportunity to observe the condition of the skin. The nurse assistant can also use this time to talk with the client. A bath relaxes and refreshes, helping clients to feel better about themselves.

Types of Baths

The type of bath given to a client will depend on several factors, such as the client's need, mobility, preference, physician's orders, and plan of care. The nurse assistant is usually told what type of bath to administer to a client. If the nurse assistant determines a need to change the type of bath based on a client's condition, he or she should consult the supervisor.

There are five types of baths commonly used in health care settings. A **complete bed bath,** also called a bed bath, involves washing the total body while a client is in

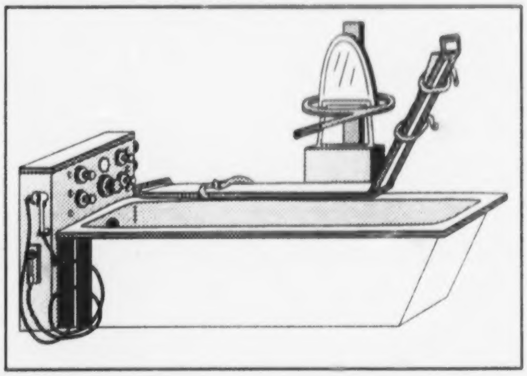
Figure 4.1 - Complete Bed Bath



bed. A complete bed bath is given to a client who is too weak, ill, or disabled to bathe himself or herself. The client may or may not be able to give any assistance with the bath. See Figure 4.1. The **partial bed bath** involves washing only the face, hands, axillae, and perineal area while a client is in bed. This bath may be done on days when a complete bed bath is not given or if a client is too ill to tolerate a complete bed bath.

The **tub bath** is given in a regular bathtub to clients who are mobile and may prefer the greater relaxation of being partially submerged in water. The **whirlpool tub bath** is found primarily in long-term care. It requires a special whirlpool tub that has a chair that mechanically lifts a client into the tub as seen in Figure 4.2. The client remains seated in the chair during the bath. The tub is powered to create a whirlpool action for greater cleansing.

Figure 4.2 - Whirlpool Tub

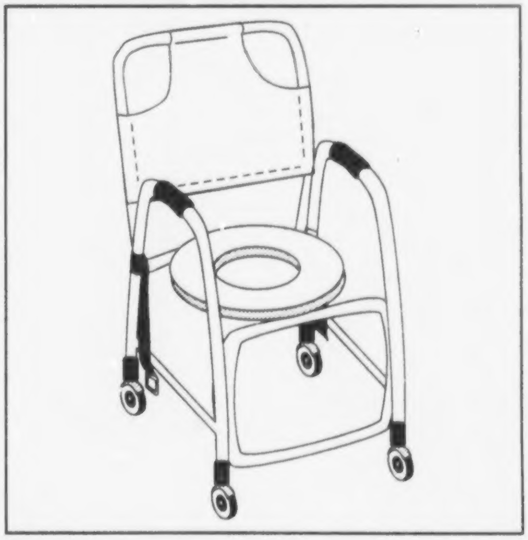


The **shower bath** is given in a shower with the client either standing up or sitting in a chair. This type of bath may be preferable for clients who have difficulty with mobility or with getting into and out of a bathtub. A home bathroom that has a tub but no showerhead can be equipped with a long, flexible, hand-held shower nozzle. The client can shower in the bathtub while seated on a portable shower chair like the one shown in Figure 4.3.

General Considerations When Bathing Clients

The room in which bathing is done should be warm and without drafts to prevent the client from becoming chilled. The client should be exposed as little as possible before, during, and after bathing. A bath blanket can be used to cover the client if one is available. If a bath blanket is not available, large towels can be draped across the exposed body parts. Even during a tub or shower bath, the client may prefer to have a towel draped over the

Figure 4.3 - Shower Chair



shoulders after the upper body has been washed. The towel will make the client feel warmer and less exposed.

The client should use the toilet before bathing as the sound and feel of warm water often stimulates the urge to urinate or defecate. Soap residue should be thoroughly rinsed off of the skin to prevent the skin from drying out. A mitten made of a washcloth will prevent dangling, dripping and dragging wet ends over the client. When giving a complete or partial bed bath, the water should be changed frequently to prevent it from becoming soapy, cold or dirty.

If the client has an IV or any drainage tubes, they should NOT be pulled on, kinked or placed under a client's extremity or body. A drainage tube should NOT be raised above the drainage site. Also, the IV container should be kept higher than the infusion site. Clients receiving oxygen may be bathed with the oxygen tubing only being removed long enough to bathe the face. Particular attention should be given to cleansing any secretions from around the nostrils.

Clients should be asked if they prefer soap or another type of cleanser to wash their faces. All supplies should be gathered and placed within easy reach during the bath so that clients will not be left alone. Each client should be observed continuously for any signs of distress during the procedure. If signs of distress are present, it may be necessary to stop the bath and notify the supervisor.

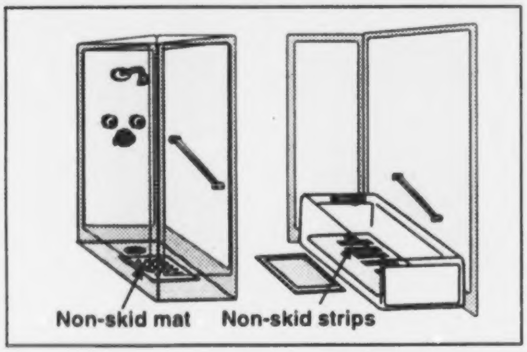
The use of gloves during bathing is a controversial issue. Many bathing procedures followed in health care facilities say that gloves are to be worn for all types of bathing. The purpose of wearing non-sterile gloves is to protect the wearer from contact with blood and body secretions and to protect the client from cross-contamination. A client being bathed who is continent and has no open, draining lesions does not pose a hazard to the nurse assistant or client, so gloves are not necessary. If the client has body secretions of any type, gloves should be worn. If secretions are present, a tub or whirlpool tub bath may not be bathing options. It is very difficult to keep water out of gloves while assisting a client with bathing. If water contaminated with blood or body fluids enters the gloves, the gloves should be removed immediately and the hands washed thoroughly, preferably with an antibacterial/disinfectant soap.

Safety Measures Required During Bathing

The temperature of the water should be between 90°F and 105°F. The nurse assistant can check the water temperature by submerging his or her hand in the water to slightly above the wrist. If the water feels too hot, it will be too warm for the client. The bathroom door should NEVER be locked if bathing is being done in that room. If the client is mobile and alert, he or she may be left alone briefly in the tub or shower, but should be checked on frequently. The nurse assistant should assist with all transfers in and out of the tub or shower. If there is any doubt about a client's ability to manage the procedure safely on his or her own, the nurse assistant should remain in the room. The nurse assistant should remember to practice good body mechanics during the bathing procedure.

Non-skid strips or a non-skid mat should be used in the bottom of the tub or on the shower floor to prevent falls (see Figure 4.4). The bathroom should also have handrails or grab bars the client can use to move in and out of the tub or shower. If appropriate, a call device should be present

Figure 4.4 - Non-Skid Mat and Strips



in the bathroom for the client who requires assistance. If bathing is done in the client's home and another person is in the home, the home health aide should establish a signal to use with this person to indicate needed assistance. If no other person is in the home who can help, the home health aide should know the location of the nearest telephone to call for outside assistance.

For client safety during a tub bath, the tub should be filled with just enough water to cleanse the client. Keeping the amount of water used to a minimum lessens the chance of the client drowning. The client should NOT be allowed to stay in the tub for too long. Staying in a tub of warm water for longer than 10-15 minutes may relax the muscles too much. The client may not have the strength to get out of the tub. Also, the water becomes cooler the longer the client stays in it and could cause the client to become chilled. Bath oil should NOT be used in the tub due to the danger of slipping and falling. Soap should be removed from the water during the bath and the tub should be drained partially or completely before the client attempts to get out. Getting out of an empty tub is easier for the client. Figure 4.5 lists the steps for a nurse assistant to take if a client becomes faint in the bathtub.

Specific safety for the shower includes keeping the hand-held shower nozzle off the floor to prevent falls (see Figure 4.6). Shower chairs should have a locking mechanism to prevent the chair from moving during the shower. The chair is positioned facing the door of the shower. The nurse assistant should stand facing the client for better control if the client should become faint or need to leave the shower stall. For home showers, shower chairs can be rented or purchased from an equipment supplier. If this is not an option, a sturdy, stable, waterproof chair can be placed in the shower to allow the client to sit throughout the shower or for portions of it. Soap should NOT be left lying on the floor of the shower as this results in slick areas that may cause a fall.

Figure 4.5 - Management of a Client Who Becomes Faint in a Bathtub

1. Call for help.
2. Support the client with his or her head out of the water.
3. Drain the water out of the tub.
4. Once the water is drained, lower the client's head as much as possible.
5. Cover the client with a bath blanket or towel.
6. Wait for the supervisor to assess the client's condition.
7. Gain assistance to lift the client from the bathtub and return the client to bed.

NOTE: In home health, another person may not be available. Even if a caregiver is present, he or she may be unable to assist with lifting the client. Steps 2 to 5 can be completed as stated. If the client does not revive enough to be assisted out of the tub or is too weak to step over the tub rim, the home health aide should notify the supervisor and ask for directions about how to proceed.

Figure 4.6 - Shower Safety

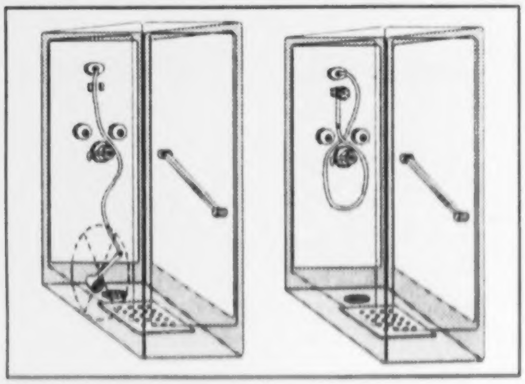


Figure 4.7 - Management of a Client Who Becomes Faint in a Shower

1. Call for help.
2. Support the client.
3. Turn off the water.
4. If the client is standing, have him or her sit.
5. If no chair is available, slide the client down the wall of the shower to sit on the floor.
6. Lower the client's head as much as possible.
7. Cover the client with a bath blanket or towel.
8. Wait for the supervisor to assess the client's condition.
9. Gain assistance to lift the client and return the client to bed.

NOTE: In home health, another person may not be available. Even if a caregiver is present, he or she may be unable to assist with lifting a client. Careful planning before beginning the shower is needed. If possible, have a chair close to the shower. Steps 2 to 7 can be completed as stated. If the client cannot help the home health aide enough to return to bed, the aide should notify the supervisor and ask for directions about how to proceed.

Figure 4.7 lists the steps for a nurse assistant to take if a client becomes faint in the shower.

Adaptations for Bathing in the Home

All types of bathing can be done in the home depending upon the equipment available. Few adaptations for a complete or partial bed bath are needed for the home. Bath blankets will probably not be available, but a light, cotton blanket or large towels can be substituted. The client's mattress may not have a protective plastic covering, so the home health aide must take care to keep water off the bed linens and from soaking through to the mattress. The home health aide will need to use bathing products supplied by the family, although these may not be products of his or her own choice. Health care equipment, such as overbed and bedside tables may not be available for placement of supplies. Bath basins and soap can be placed on nightstands or other small household tables. The home health aide should protect the table surface with a waterproof or thick absorbent cover and be careful about spilling water. Bath water carried a distance from the bathroom or kitchen will cool more rapidly, so the nurse assistant may need to change the water more frequently.

If the shower in the home is a self-contained stall, few adaptations will be needed. The home health aide should make sure that the client has enough mobility to step up over the edge of the shower. As discussed earlier, a shower chair will make the procedure safer.

A tub bath should only be given in the home if the client has the ability to raise and lower himself or herself from the tub. This method of bathing may not be an option unless the client has that ability or the family is willing to purchase or rent adaptive equipment. The nurse assistant should suggest adaptive equipment, such as a bath chair and flexible shower nozzle, but it is the family's choice whether or not to follow these suggestions.

Steps of Procedure for Giving a Complete Bed Bath

1. Wash your hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify yourself.
5. Explain what you are going to do.
6. Provide privacy.
7. Wash hands.
8. Put on gloves.
9. Assist with oral hygiene and shaving (if applicable).
10. Offer toileting.
11. When client completes toileting; empty, clean, and put away equipment.
12. If client uses toileting facilities, remove and appropriately dispose of gloves, wash hands and put on clean gloves.
13. Place client in supine position near side of bed where it is most comfortable for you to stand during procedure.
14. Untuck bed linens.
15. Remove bedspread and blanket; fold and place on a chair if reusing, otherwise place in linen bag.
16. Cover top sheet with a bath blanket. Ask client to hold bath blanket in place; if client is unable to hold, tuck only the bath blanket under client's shoulders.
17. Remove top sheet by pulling it out from under bath blanket and place it in linen bag at the bedside.
18. Remove client's gown or pajamas.
19. Place a face towel across client's chest.
20. Fill bath basin 2/3 full of warm water.
21. Wet washcloth and squeeze out excess water.
22. Wash around eyes first. Start at inner corner and work out. Use different area of washcloth for each eye.
23. Wash, rinse and dry face, ears, nose and mouth using face towel on client's chest.
24. Wash, rinse and dry neck.
25. Expose arm farthest from you.
26. Place a bath towel lengthwise under arm from axilla to fingertips.
27. Place basin of water on bed next to client's hand and immerse hand in water and wash.
28. Remove basin.
29. Wash and rinse shoulder, axilla, arm and hand.
30. Dry shoulder, axilla, arm and hand.
31. Repeat steps 24-29 with arm closest to you.
32. Fingernail care may be done.
33. Place a bath towel across chest, pulling bath blanket down from under towel and folding it to waist.
34. Wash and rinse chest and breasts while lifting towel up from bottom.
35. Dry skin thoroughly.
36. Fold bath blanket to perineal area, keeping chest covered with a towel.
37. Wash, rinse and dry abdomen.
38. Draw bath blanket back up over towel and remove towel by pulling it out from under bath blanket.
39. If bath water has not needed changing previously, it MUST be changed at this point.
40. Expose farthest leg; flex or bend leg and place a towel lengthwise under leg up to the buttocks.
41. Place bath towel lengthwise under leg from buttocks to toes.
42. Wash and rinse leg and foot.
43. Dry leg, foot and between the toes.
44. Repeat steps 39-42 on leg nearest to you.

45. Cover client with bath blanket.
46. Toenail care may be done at this point.
47. Place towel and washcloth in linen bag and get clean ones.
48. Change bath water in basin.
49. Ask or help client to turn on side with back facing you.
50. Fold bath blanket over client's side to expose back and buttocks.
51. Place a clean bath towel lengthwise parallel to client's back.
52. Wash, rinse and dry back and buttocks.
53. Remove and appropriately dispose of gloves.
54. Wash hands.
55. Give back rub using warmed lotion paying special attention to bony areas. If client has open lesions or draining wounds, put on a clean pair of gloves before giving back rub.
56. If gloves were used to give back rub, remove and appropriately dispose of gloves.
57. Wash hands.
58. Put on clean gloves.
59. Turn client on back.
60. Place a clean towel under buttocks.
61. If client is able, provide washcloth, soap and towel and instruct him or her to wash and dry perineal area.
62. If client is unable, wash perineal area from front to back.
63. If client did own perineal care, provide fresh water to wash hands.
64. Collect dirty linen and place in an appropriate container.
65. Remove and appropriately dispose of gloves.
66. Wash hands.
67. Apply warmed lotion as needed and deodorant. If client has open lesions or draining wounds, put on clean gloves before applying lotion or deodorant.
68. Assist client to dress.
69. Comb hair and apply cosmetics, if applicable.
70. Remove, clean, and store equipment.
71. Make client comfortable.
72. Place call device within reach, if applicable.
73. If gloves were used to apply lotion and deodorant, remove and appropriately dispose of gloves.
74. Wash your hands.
75. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Giving a Tub Bath

1. Wash your hands.
2. Check to see that bathtub and shower chair are clean.
3. Place a nonskid mat in bathtub.
4. Place a nonskid floor mat next to bathtub.
5. Place a chair next to bathtub.
6. Assemble necessary supplies and equipment.
7. Identify and greet client.
8. Identify yourself.
9. Explain what you are going to do.
10. Wash hands.
11. Put on gloves.
12. Offer toileting.
13. When client completes toileting; empty, clean, and put away equipment.
14. If client uses toileting facilities, remove and appropriately dispose of gloves, wash hands and put on clean gloves.
15. Assist client to put on robe and slippers.
16. Ambulate or transport client by whirlpool chair or wheelchair to tub room.
17. Close tub drain and fill with water at least half-full.
18. Check water temperature.
19. Assist client to undress.
20. Assist client into tub.
21. Assist client in washing as needed. If client is unable to help, wash

around eyes first, then wash face, ears and neck. After washing head, wash arms, hands, chest, abdomen and back. Rinse with warm water.

22. Wash legs, feet and between toes. Rinse thoroughly with warm water.
23. To wash perineal area, ask or assist client to turn slightly to one side. Rinse from front to back.
24. Open tub drain and drain completely.
25. Help client out of tub, cover with a bath blanket and assist to chair.
26. Remove and appropriately dispose of gloves.
27. Wash hands.
28. If client has open wounds or drainage, put on a clean pair of gloves.
29. Uncover client, one area at a time, and pat dry with a towel.
30. Apply powder, lotion and deodorant, if applicable.
31. Assist client to dress.
32. If gloves were put on to dry and dress client, remove and appropriately dispose of them and wash hands..
33. Return client to room and assist with any personal care such as shaving, nail care and hair care.
34. Make client comfortable.
35. Place call device within reach, if applicable.
36. Return to tub room and put on gloves.
37. Remove soiled articles and clean tub with disinfectant solution.
38. Remove and appropriately dispose of gloves.
39. Wash your hands.
40. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Giving a Whirlpool Tub Bath

NOTE: The following general procedure is applicable to all whirlpool tubs; however, each facility may have unique cleaning procedures or policies about giving baths that are specific to that facility.

1. Wash your hands.
2. Check to see that whirlpool tub and chair are clean.
3. Obtain chair from tub if it is a detachable, mobile model. If not, obtain a means of transporting client to whirlpool tub room.
4. Assemble necessary supplies and equipment.
5. Identify and greet client.
6. Identify self.
7. Explain what you are going to do.
8. Wash hands.
9. Put on gloves.
10. Offer toileting.
11. When client completes toileting; empty, clean, and put away equipment.
12. If client uses toileting facilities, remove and appropriately dispose of gloves, wash hands and put on clean gloves.
13. Assist client to put on robe and slippers.
14. Ambulate or transport client to whirlpool tub room.
15. Transfer client to whirlpool chair.
16. Close tub drain and fill with water at least half-full.
17. Assist client to undress.
18. Secure safety straps and cover client with a bath blanket.
19. If tub chair is detachable and has been used as a means of transport, engage seat on lift. Make sure pins are locked in lift arm slots and safety latches are closed.
20. Put on gloves if they were removed earlier after toileting.

21. Step on "up" pedal and lift chair to its maximum height.
22. Turn chair on lift arm so client swings to side of tub.
23. Facing client, lift client's feet over edge of tub.
24. Turn chair so it is positioned directly over tub.
25. Step on "down" pedal and let chair lower into water.
26. Push whirlpool button. Water must be above level of jet port to function properly.
27. Assist or bathe client's face and neck. Follow facility policy regarding use of soap in whirlpool tub.
28. Assist or bathe client's arms, chest, abdomen, back, buttocks and perineal area.
29. Step on "up" pedal, raising client until feet are level with whirlpool outlet.
30. Dry upper body and drape a towel or bath blanket around shoulders.
31. Bathe client's legs and feet.
32. Raise lift to maximum height.
33. Pull chair toward you, lifting client's feet over edge of tub.
34. Dry feet and legs.
35. Cover legs with a bath towel.
36. Lower lift until client's feet are flat on floor.
37. Remove and appropriately dispose of gloves.
38. Wash hands.
39. If client has open wounds or drainage, put on a clean pair of gloves.
40. Apply powder, lotion, and deodorant, if applicable.
41. Unfasten safety belt.
42. Assist client to dress.
43. If gloves were put on to dress client, remove, appropriately dispose of them and wash hands.
44. Return the client to room and assist with any personal care such as shaving, nail care and hair care.
45. Make client comfortable.
46. Place call device within reach, if applicable.
47. Return to whirlpool tub room and put on gloves.
48. Remove soiled articles and clean tub according to facility guidelines.
49. Remove and appropriately dispose of gloves.
50. Wash your hands.
51. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Giving a Shower Bath

1. Wash your hands.
2. Check to see that shower and shower chair are clean.
3. Place a nonskid mat in shower stall if client will stand during shower.
4. Assemble necessary supplies and equipment.
5. Identify and greet client.
6. Identify yourself.
7. Explain what you are going to do.
8. Wash hands.
9. Put on gloves.
10. Offer toileting.
11. When client completes toileting; empty, clean, and put away equipment.
12. If client uses toileting facilities, remove and appropriately dispose of gloves, wash hands and put on clean gloves.
13. Assist client to put on robe and slippers.
14. Ambulate or transport client to shower room using shower chair.
15. Assits client into shower. If shower chair is used, lock wheels.
16. Wash hands and put on gloves, if they were removed earlier after toileting.
17. Assist client to undress.
18. Cover client with a bath blanket until ready to start shower.
19. Adjust spray temperature.

20. Assist client in washing as needed. If client is unable to help, wash around eyes first, then wash face, ears and neck. After washing head, wash arms, hands, chest, abdomen and back. Rinse with warm water.
21. Wash legs, feet and between toes. Rinse thoroughly with warm water.
22. Wash and rinse perineal area front to back. If shower chair is used, wash female labia from front of chair and anal area from under chair.
23. Wash between buttocks and rinse well from front to back.
24. Turn off shower and cover client with bath blanket.
25. Assist client out of shower.
26. Remove and appropriately dispose of gloves.
27. Wash hands.
28. If client has open wounds or drainage, put on a clean pair of gloves.
29. Uncover client, one area at a time, and pat dry with towel.
30. Apply powder, lotion and deodorant, if applicable.
31. Assist client to dress.
32. If gloves were put on to dry and dress client, remove and appropriately dispose of them and wash hands.
33. Return client to room and assist with any personal care such as shaving, nail care and hair care.
34. Make client comfortable.
35. Place call device within reach, if applicable.
36. Return to shower room and put on gloves.
37. Remove soiled articles and clean shower and shower chair with disinfectant solution.
38. Remove and appropriately dispose of gloves.
39. Wash your hands.
40. Record pertinent observations and report unusual occurrences to supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 4: Bathing

Activity Sheet

1. List six purposes of bathing.

   a. ______________________ d. ______________________

   b. ______________________ e. ______________________

   c. ______________________ f. ______________________

2. List and describe the five types of baths.

   a. ____

   b. ____

   c. ____

   d. ____

   e. ____

3. List two measures to take when assisting with bathing to prevent the client from becoming cold.

   a. ____

   b. ____

4. How can you prevent the washcloth from dangling and dripping water over the client?

   ____

5. What are the four precautions a nurse assistant should consider when bathing clients with IVs or drainage tubes?

   a. ____

   b. ____

   c. ____

   d. ____

6. What should you do if the client becomes distressed during the bathing procedure?

____

7. Describe four safety measures you should follow during bathing.

a. ____

b. ____

c. ____

d. ____

8. Describe three safety measures you should follow during a shower bath.

a. ____

b. ____

c. ____

9. What are the seven steps for managing a client who becomes faint during a tub bath ?

Step 1: ____

Step 2: ____

Step 3: ____

Step 4: ____

Step 5: ____

Step 6: ____

Step 7: ____

10. Describe three safety measures you should follow during a tub bath.

a. ____

b. ____

c. ____

11. What are the nine steps for managing a client who becomes faint during a shower?

    Step 1: ____________________

    Step 2: ____________________

    Step 3: ____________________

    Step 4: ____________________

    Step 5: ____________________

    Step 6: ____________________

    Step 7: ____________________

    Step 8: ____________________

    Step 9: ____________________

12. List five adaptations that can be made for bathing in the home.

    a. ____________________

    b. ____________________

    c. ____________________

    d. ____________________

    e. ____________________

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedures, practice the following activities with a partner in a laboratory.

    a. Practice placing a bath blanket and towels for minimum exposure of a client.

    b. Practice making a mitten of a washcloth.

    c. Follow the steps of procedure of a complete bed bath without using water.

    d. Role-play the management of a client who becomes faint in the bathtub or shower.

    e. Practice checking water temperature to determine if it is appropriate.

2. Examine your home and determine the adaptations you would need to make if you were a home health aide who was responsible for giving a complete bed bath, a tub bath, and a shower bath. Discuss what you find in class.

Lesson 5: Shaving

Objectives:

A. Discuss general considerations for shaving a client.

B. Shave the client with a safety razor.

C. Shave the client with an electric razor.

Key Terms:

- Anticoagulants

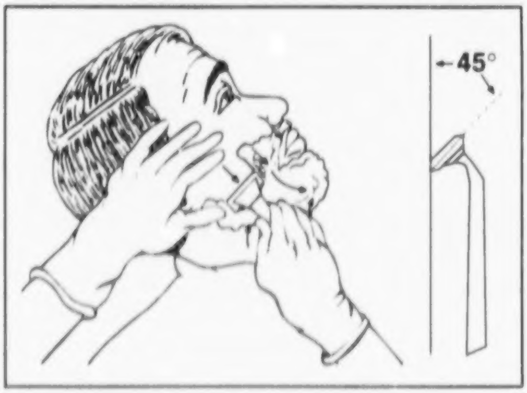
Shaving is part of daily grooming for males and some females. For clients who are ill or weak, this procedure may only need to be done once or twice a week. Nevertheless, it should be part of the routine personal care procedures that the nurse assistant completes or assists with for clients. Shaving can be done anytime during the day, but most people prefer it to be done as part of the morning routine.

General Considerations for Shaving a Client

Clients who are able may prefer to shave themselves. They should be allowed to do so as this provides some exercise for them and enhances their feelings of accomplishment. Many females have facial hair and wish to have it shaved, or they may request that their underarms and legs be shaved. Shaving is done in a client's room or a bathroom, NEVER in a public area. Clients should use their own shaving equipment. They should not share shaving equipment without proper sanitization. If the client has no personal shaving equipment, a disposable safety razor can be used. The safety razor is held at a 45-degree angle to the client's skin while shaving as seen in Figure 5.1. Electric razors are the easiest and safest to use on the client, but the nurse assistant should consider the client's personal preference. Clients who are receiving oxygen may only use an electric razor if the oxygen can be removed during the procedure. If the client is receiving **anticoagulants**, medications that delay the clotting of the blood, an electric razor should be used to prevent nicking the skin and causing bleeding.

Lather or shaving cream is applied before shaving with a safety razor to soften the hair and prevent skin irritation. Warm water, rather than cool, softens a beard better and makes shaving smoother. For the greatest comfort and ease, shaving the face should be done in the direction that hair grows, using short, firm strokes. Safety razors should be disposed of in a sharps container. During shaving, if the skin is nicked and bleeds, the nurse assistant should put on gloves (if not already being worn) and apply pressure to the nick using a clean cloth. Pressure should be applied for at least a minute or until the bleeding stops. The supervisor should be notified of the occurrence. If using an electric razor near water, such as

Figure 5.1 - Shaving with a Safety Razor



at the bathroom sink, the shaver and the electrical cord should not come in contact with water.

Steps of Procedure for Shaving a Client with a Safety Razor

1. Wash your hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy
7. Wash hands.
8. Put on gloves.
9. Position client in chair or sitting position in bed in well-lit area.
10. Spread a towel under client's chin.
11. Wet face with warm water.
12. Apply a thick layer of shaving cream to face.
13. Leave lather in place about 15-30 seconds.
14. Using a downward stroke with razor, start under hairline in front of ear and work over cheek.
15. Rinse razor often in water.
16. Continue over chin, pulling skin tight to reach hair in depression under lip.
17. Work upward on neck under chin, tipping head back to tighten skin of neck, and around to other side of face.
18. Shave area around lips carefully. Ask client to draw upper lip down over teeth to tighten. Assist client if he or she cannot stretch skin tight.
19. When finished shaving, wash face of any excess soap or lather.
20. Pat face dry with towel.
21. Apply aftershave lotion if client requests it.
22. Remove towel from under chin.
23. Place call device within reach, if applicable.
24. Remove, clean and store equipment.
25. Remove and appropriately dispose of gloves.
26. Wash hands.
27. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Shaving a Client with an Electric Razor

1. Wash your hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy.
7. Wash hands.
8. Put on gloves.
9. Sanitize razor head.
10. Position client in chair or sitting position in bed in well-lit area.
11. Spread a towel under client's chin.
12. Wash face thoroughly with soap and water to remove dirt and oil.
13. Apply preshave lotion if client requests it.
14. Start shaving on one side of face below hairline in front of ear. Hold skin tight and use circular motions. Shave neck, around mouth, and over to other side of face and neck.
15. When finished, apply aftershave lotion if client requests it.
16. Remove towel from under chin.
17. Sanitize razor head.
18. Place call device within reach, if applicable.
19. Remove, clean and store equipment.
20. Remove and appropriately dispose of gloves.
21. Wash hands.
22. Record pertinent observations and report unusual occurrences to supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 5: Shaving

Activity Sheet

1. Where should a client shave or be shaved?

2. What should you use if the client does not have personal shaving equipment?

3. What should you do about shaving the client if he or she is receiving oxygen?

4. What type of razor should be used to shave a client receiving anticoagulants?

5. What can be done to soften the beard and make shaving easier?

   a. Using a safety razor: ______

   b. Using an electric razor: ______

6. What should you do if the client is nicked and bleeds while you are shaving him or her?

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedures, practice the following activities with a partner in the laboratory.
    a. Examine an electric razor and practice taking the head off, putting it back on, and cleaning it.
    b. With the safety cap in place, practice holding the safety razor at the proper angle for shaving against a partner's face and neck.
    c. Practice holding the skin tight around the mouth to get the smoothest shave.
    d. Practice applying shaving cream.
2. Ask a male friend or relative if he will allow you to shave him with either a safety razor or an electric razor.
3. Female students should discuss shaving facial hair with men to gain tips for successful shaving. Male students should discuss shaving underarms and legs with women to gain tips for successful shaving. Share any special tips with fellow students in a class discussion.

Lesson 6:
Hair Care

Objectives:

A. Identify the purposes of hair care.

B. Discuss general considerations in giving hair care.

C. Identify safety precautions that should be taken while giving hair care.

D. Identify special hair care needs.

E. Comb or brush hair.

F. Give a shampoo during a tub or shower bath.

G. Give a bed shampoo.

Key Terms:

- Infestations
- Dry shampoo

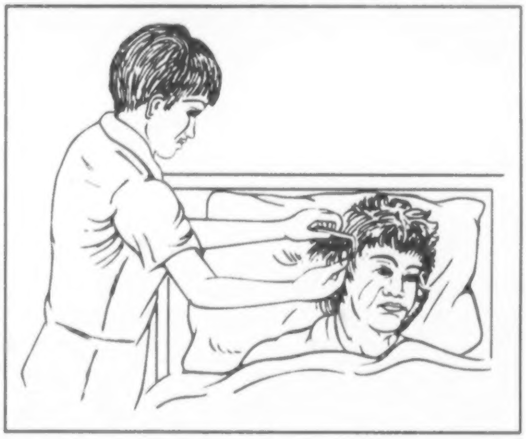
Proper care and styling of a client's hair is important to his or her appearance. A nurse assistant does not need to be a talented hair stylist. Simple combing, brushing, and shampooing are wonderful morale boosters for clients who are unable to complete these tasks for themselves.

Purposes of Hair Care

The primary purpose of hair care is to improve the client's appearance. Those who are ill may feel that they look bad enough without adding matted, tousled hair to the picture. Since hair is a part of the skin, it needs to be cleansed of dirt particles and dead cells to keep it healthy. Clients' hair can become twisted and tangled from lying in bed or rolling from side to side. The heat from the head causes the scalp to perspire, dampening the hair and causing the tangles to mat. Frequent combing or brushing prevents hair from becoming tightly tangled and matted. Removing small tangles is easier for the nurse assistant and the client than trying to comb or brush hair that has been left tangled and matted too long. (See Figure 6.1.) Combing or brushing also stimulates circulation to the scalp, bringing needed nutrients to the roots where life and growth of the hair are maintained. While doing hair care, the nurse assistant should observe the scalp. Sores, redness, dryness and swollen areas that might be symptoms of disease may be hidden under the hair.

The nurse assistant should observe the hair for the presence of lice or other insects. Anyone can have an **infestation**, the presence of parasites on the skin or in the hair. Usually this occurs when hair is improperly maintained or from contact with a person who has lice or insects. Lice are also spread by sharing personal hair care items, or items such as hats and scarves. Using good observation skills and discouraging the use of personal hair care

Figure 6.1 - Combing Hair



items or other personal items by more than one client will prevent infestations.

Clients who do their own hair care will receive mild exercise of the hands and arms. Clients who have undergone some surgical procedures may be required to do their own hair care. For example, hair care can exercise the arm muscles affected by breast removal.

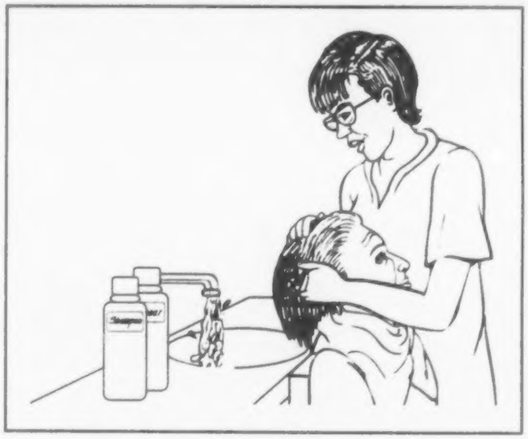
General Considerations in Giving Hair Care

Combing and brushing should be done in the morning as part of the early morning personal care routine. Hair care may need to be done at various times again during the day to maintain the client's appearance. Some clients prefer to take care of their own hair with the nurse assistant only providing the supplies for them to do so. Others cannot mentally or physically accomplish the task. Some clients may only need a reminder to complete the procedure. Clients may prefer the facility's hair stylist or a beauty salon. The client's or family's permission is required to make an appointment at a beauty salon. Between appointments, the nurse assistant should observe the client's appearance and make minor repairs in style as needed. If the nurse assistant is responsible for hair care, he or she should style the hair as the client wishes. If the client is unconscious or unable to voice an opinion about hair style, an attractive, simple style should be chosen. Hair cannot be cut without the client's or family's permission, and the nurse assistant should refrain from coloring a client's hair.

For clients in acute care, giving a shampoo requires a physician's order. For clients in long-term or home health care, shampooing should be part of routine personal care. Young clients may wish to have their hair washed daily. For older clients, hair should be washed at least weekly. If dirt and hair oil accumulate rapidly, the hair should be washed as often as needed to promote cleanliness.

Shampooing can be done in many places. The nurse assistant must determine the best shampooing method depending on the client's mobility and strength. The easiest method is to shampoo the client's hair while in the shower. The client may either stand under the spray or sit in a shower chair, so that the nurse assistant may use a shower nozzle to direct the water on the head. A sink may be used if a home health care client is flexible enough and has endurance to stand bent over. A bathroom sink can also be used in the home if it is large enough and low enough for the client to access. A low-backed chair can be placed against the sink and the client seated with his or her back facing the sink as seen in Figure 6.2. The client leans back and rests the back of his or her head on the sink rim. Towels should be rolled and placed under the client's neck to protect his or her clothing. A container should be used to pour water over the client's head. The client must be able to hold still and not slip out of the chair

Figure 6.2 - Shampooing Hair



during the procedure. This procedure can also be used in a long-term care facility.

A client may feel chilled more quickly with wet hair, so the room where any wet shampooing is done should be at least 75°F to 80°F and free of drafts. Shampoo should be thoroughly rinsed from the scalp to prevent skin irritation and dryness. Using a solution of one part white vinegar to five parts water, followed by a clear water rinse, will remove soapy residues from the hair.

A client in a long-term care facility who cannot move may be transported on a gurney to a utility room that has a sink or a shower with a spray nozzle extension. For clients who cannot be moved out of bed, a bed shampoo, a dry shampoo, or a combination of the two must be used. A **dry shampoo** is a commercial preparation, usually foam based, that absorbs the excess oil and accumulated dirt in the hair. The foam is applied and worked into the hair and scalp. It is then combed or brushed out and the hair is allowed to dry. Several dry shampoo products are available where hair care products are sold. The directions for product use are found on the label. A client's hair may also be washed in a whirlpool tub with a water hose extension. The client should bend forward or to tilt his or her head to the back of the tub.

Whether the hair is wet or dry, tangle-free hair should be combed or brushed from the scalp to the ends. Tangles should be separated from the rest of the hair into sections that can be held firmly near the scalp. Tangled hair should be combed or brushed working from the ends to the scalp.

Safety Precautions in Giving Hair Care

For infection control, the client's comb and brush should be labeld with a permanent marker either directly on the items or on pieces of adhesive tape applied to them. This prevents cross-contamination of infectious organisms from the sharing of items. Also, hair rollers or curlers should NOT be shared between clients. Placing a towel around the client's shoulders while combing or brushing the hair prevents hair and dead cells from the scalp from being deposited on clothing and the surrounding environment. Hairs shed during the procedure can be rolled into the towel when combing or brushing is completed. The towel should then be placed in a soiled linen receptacle. Combs and brushes must be cleaned after each use. Hair and debris left in combs or brushes is unsightly and provides a breeding ground for microorganisms.

If a nozzle is being used to apply water to the hair, one finger should be kept in the stream of water to monitor water temperature and pressure. The scalp is more sensitive to heat than the skin on all other parts of the body; water temperature for any type of shampooing should be a maximum of 105°F.

Hair dryers should be used with extreme caution. The temperature should be kept on low and checked frequently. If using a hand-held dryer, the nurse assistant can keep a hand under the air stream so the temperature can be monitored. To prevent electrocution, do not use hair dryers near a tub or over a sink full of water.

Special Hair Care Needs

Hair texture varies from client to client. Clients with thick, coarse hair will need special hair care. This hair type should only be washed once a week or once every two weeks. The hair and scalp should be oiled lightly each week if the hair is very dry. A wide-tooth comb is best for working with this hair type. Professionally straightened hair can be maintained by rolling the hair on sponge curlers wrapped in paper or tissue each night and by lightly oiling the hair and scalp weekly.

The shampooing procedure is the same for all hair types, but a special professional shampoo or a softening shampoo, such as a baby shampoo, is best for washing coarse hair. After shampooing, the hair should be gently dried with a towel and combed out while still damp. Because this hair type tangles easily, a conditioning detangler should be applied. If hair is allowed to dry while hanging loose, it must be constantly combed to prevent tangles. If the client wishes his or her hair to be curled, a wet-hair setting lotion can be applied to each hair section before rolling it on rollers. If the hair is braided while it is damp, it will take hours to dry. A hair dryer can be used after braiding to speed up the drying process.

Steps of Procedure for Combing or Brushing Hair

1. Wash your hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy.
7. Wash hands.
8. Place client's towel across pillow if client is in bed. For sitting client, place towel around shoulders.
9. If client wears glasses, put them in a safe place.
10. Remove any hairpins, combs, etc.
11. Brush or comb hair gently using downward strokes, making sure all sections of hair are combed/brushed and all areas of scalp stimulated.
12. Arrange hair to client's satisfaction.
13. Let client use hand mirror to approve appearance or request adjustments.
14. Roll up towel to trap hairs and debris inside roll.
15. Place towel in a soiled linen receptacle.
16. Make client comfortable.
17. Place call device within reach, if applicable.
18. Remove, clean and store equipment.
19. Wash hands.
20. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Giving a Tub or Shower Shampoo

1. Wash your hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy.
7. Wash hands.
8. Position client appropriately in tub or shower.
9. Ask client to hold a folded washcloth/face towel over eyes.
10. Apply water to hair until it is completely wet, using nozzle or pitcher.
11. Apply small amount of shampoo.
12. Work shampoo into lather, massaging well with fingertips.
13. Rinse thoroughly, working from front to back and down length of hair.
14. Repeat sudsing and rinsing, if necessary.
15. Apply vinegar water, conditioner, or creme rinse as directed.
16. Rinse thoroughly.
17. Use towel to dry hair as much as possible.

18. Encourage client to comb own hair to remove snarls and tangles, if able.
19. Apply rollers or set hair if this is to be done.
20. Dry hair with hair dryer.
21. Remove curlers.
22. Comb or brush hair into an attractive style.
23. Let client use hand mirror to approve appearance or request adjustments.
24. Make client comfortable.
25. Place call device within reach, if applicable.
26. Remove, clean and store equipment.
27. Wash hands.
28. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Giving a Bed Shampoo

1. Wash your hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy.
7. Wash hands.
8. Raise bed to its highest horizontal position.
9. Place chair or footstool at side of bed most comfortable for you to work from and near client's head; cover with a small towel.
10. Set large basin or bucket on chair.
11. Move client to side of bed nearest basin or bucket.
12. Cover with bath blanket and fanfold top linens (refer to Lesson 11) to foot of bed without exposing client.
13. Remove pillow and replace with a waterproof bed protector.
14. Place one towel under client's head and one around shoulders to protect clothing/pajamas.
15. Place shampoo trough or arrange plastic sheet under head to form drain into bucket.
16. Put a cotton ball in each ear of client.
17. Apply water to hair until it is completely wet, using a pitcher.
18. Apply small amount of shampoo. Work shampoo into lather, massaging with fingertips.
19. Rinse thoroughly, working from front to back and down length of hair.
20. Repeat sudsing and rinsing, if necessary.
21. Apply vinegar rinse, conditioner, or creme rinse as directed.
22. Rinse thoroughly.
23. Squeeze excess water from hair.
24. Remove shampoo trough and place in bucket.
25. Fold towel under head up around hair to contain wetness.
26. Remove waterproof bed protector and replace pillow.
27. Remove cotton balls from client's ears.
28. Using another towel, dry hair.
29. Encourage client to comb own hair to remove tangles, if able.
30. Apply rollers or set hair if this is to be done.
31. Dry hair with hair dryer.
32. Remove curlers.
33. Comb or brush hair into an attractive style.
34. Let client use hand mirror to approve appearance or request adjustments.
35. Make client comfortable.
36. Place call device within reach, if applicable.
37. Remove, clean and store equipment.
38. Wash hands.
39. Record pertinent observations and report unusual occurrences to supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 6: Hair Care

Activity Sheet

1. List five purposes of hair care.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

   e. ______________________________

2. When should hair care be given?

   ____

   ____

3. How often should a client's hair be washed?

   ____

4. List three places where shampooing can be done.

   a. ______________________________

   b. ______________________________

   c. ______________________________

5. Describe a dry shampoo.

   ____

   ____

6. What is the best way to remove tangles from the hair?

   ____

   ____

7. Describe three safety precautions to prevent the spread of infection when giving hair care.

   a. ____

   b. ____

   c. ____

8. Describe four safety precautions to follow when giving hair care.

   a. ____

   b. ____

   c. ____

   d. ____

9. Describe three special hair care needs for clients with coarse, thick hair.

   a. ____

   b. ____

   c. ____

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedures, practice the following activities with a partner in the laboratory.

   a. Practice combing and brushing the hair.

   b. Practice setting up your partner for a bed shampoo.

   c. Examine a dry shampoo bottle and read the directions for its use.

   d. Ask if students of different hair types are willing to let students feel their hair and practice combing it.

2. Working in groups of seven to ten students, have each individual describe his or her hair care and shampooing practices. Identify the common practices for hair care and shampooing among members of your group. Develop a master plan to care for clients' hair based on the group's common findings and present it to the rest of the class.

3. Put your hands in basins filled with water at the following temperatures: 90°F, 95°F, 100°F, and 105°F. Compare and contrast how each temperature feels.

4. Make a shampoo trough with towels and a trash bag.

Lesson 7:
Oral Hygiene

Objectives:

A. Identify the purposes of oral hygiene.

B. Discuss the general considerations in giving oral hygiene.

C. Describe the general considerations in performing denture care.

D. Assist with oral hygiene for a conscious client.

E. Provide flossing of teeth.

F. Administer oral hygiene to helpless or unconscious clients.

G. Provide denture care.

Key Terms:

- Oral hygiene
- Plaque
- Caries
- Halitosis
- Flossing

When working with clients who can no longer do their own oral hygiene, nurse assistants should keep in mind that having a bad taste in the mouth can be unpleasant. Not only is poor oral hygiene uncomfortable for the client, but it is also unhealthy; good teeth and gums are necessary to chew and digest food adequately.

Purposes of Oral Hygiene

Oral hygiene is the care of the teeth, gums and inside surfaces of the teeth and mouth. The primary purpose of oral hygiene is to remove food particles and plaque from the teeth. **Plaque** is a sticky, transparent, bacterial film found on the teeth. If plaque is not removed, it will react with sugars from foods to produce acids and toxins. These acids and toxins can dissolve the outer covering of the teeth, causing decay and irritation of the gums. Tooth decay is called **caries**. Oral hygiene is necessary to keep the teeth and gums healthy. Brushing the teeth stimulates circulation to the gums. Healthy gums are necessary to prevent the teeth from loosening and falling out. Accumulated food particles provide a food source for bacteria, which can lead to an infection if those particles remain in the mouth. Bacterial decomposition of food particles or post-nasal sinus drainage can also cause **halitosis**, or bad breath. Good oral hygiene reduces halitosis. Proper care of the mouth can eliminate bad tastes, thus making food taste better and enhancing the appetite. Performing or assisting with oral hygiene gives the nurse assistant the opportunity to observe the mouth and gums. Figure 7.1 is a list of observations to make when providing oral hygiene. The client should be encouraged

Figure 7.1 - Observations of the Mouth

- Tooth decay (blackened teeth)
- Loose or broken teeth
- Red or swollen gums
- Sores or white patches in the mouth or on the tongue
- Changes in eating habits (the client may eat only soft foods that require little chewing if mouth pain is present)
- Poorly fitting dentures

to do his or her own oral hygiene. This activity provides mild exercise for the hands and arms.

General Considerations in Giving Oral Hygiene

Clients will have their own routine regarding the times they wish oral care to be done. Some wish to brush their teeth before breakfast to get rid of "morning mouth" before they eat. Others will wish to brush their teeth after meals and at bedtime, which is the general standard the nurse assistant should follow in giving oral hygiene. Other clients may require more frequent oral hygiene. Oral hygiene should be given every two hours to unconscious clients and clients receiving oxygen because they usually breathe through their mouths, causing secretions to stick on mouth surfaces. A high temperature or dehydration can cause the mouth to be very dry. Clients experiencing these conditions will require oral hygiene to keep the membranes moist and lubricated. Vomiting leaves a very bad taste in the mouth, as do the toxins that accumulate in dying clients. Frequent oral hygiene should be given to those clients as a comfort measure.

All oral hygiene equipment must be labeled with the client's name to prevent it from being used on another client. Many diseases are easily transmitted through the mucous membranes of the oral cavity, so clients should not share oral care equipment. The teeth should be brushed by using both horizontal and vertical strokes to cover all surfaces of the teeth. The large molars in the back are sometimes hard to reach; the toothbrush should be positioned to reach those areas. If the nurse assistant must brush the client's teeth, the backs of the upper teeth are the areas most frequently missed. Brief brushing will not remove plaque. It will take at least three minutes to reach all the teeth and remove the plaque. A client should rinse his or her mouth with water and mouthwash after brushing to remove toothpaste, food particles and loosened plaque. Some clients may not like the strong flavor of mouthwash. If so, mouthwash may be diluted by using a solution of one part mouthwash to one part water. Using mouthwash does not replace brushing teeth.

Flossing is the use of a specially waxed or unwaxed string to remove particles of food from between the teeth and to stimulate the gums. Flossing is a part of many clients' daily oral hygiene routine. Figure 7.2 provides an illustration of flossing.

General Considerations in Giving Denture Care

Dentures are very expensive, so careful handling is necessary to prevent them from being damaged. Holding dentures with a washcloth or a paper towel prevents them from slipping out of the nurse assistant's hands when they are wet and slick. Placing a washcloth or a paper towel in the sink when cleaning dentures

Figure 7.2 - Flossing Teeth

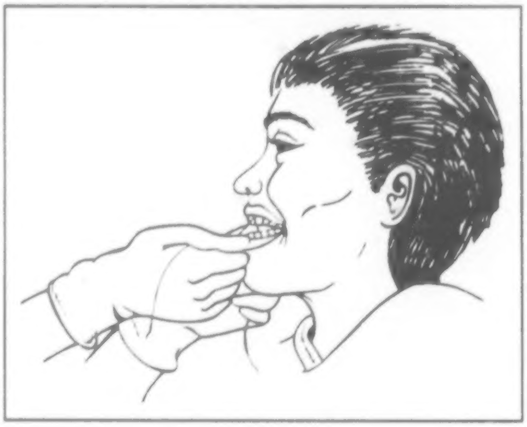
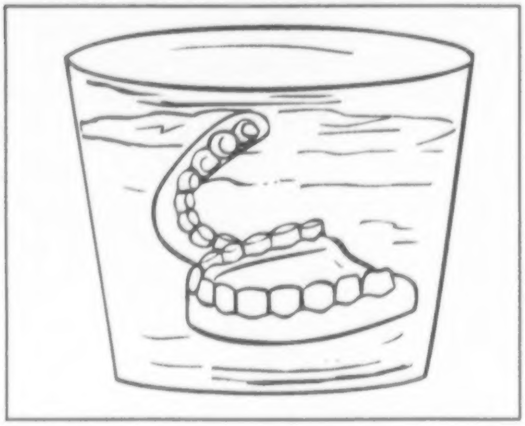


Figure 7.3 - Soaking Dentures



provides a cushion if they should fall, or dentures can be cleaned over a partially filled sink. Dentures should be kept in clean, cool water when they are not in the mouth to keep them from warping, as seen in Figure 7.3. Hot water should not be used to clean or store dentures because the heat may loosen the teeth. If dentures are removed at night, they should be stored in a denture cup labeled with the client's name. If the client prefers, a cleansing tablet can be put in the water and the dentures can be soaked overnight. Soaking dentures in denture solution does not eliminate the need for daily brushing.

Steps of Procedure for Assisting a Conscious Client with Oral Hygiene

1. Wash your hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Wash hands.
7. Put on gloves.
8. Provide privacy.
9. Dilute mouthwash (one part mouthwash to one part water) if client wishes.
10. Assist client to bathroom or an upright sitting position.
11. Pour water over toothbrush; instruct or assist client to put small amount of toothpaste on toothbrush.
12. Instruct or assist client to brush horizontally along gum line.
13. Instruct or assist client to brush teeth up and down from crown to edge on both front and back surfaces of teeth.
    NOTE: Client may need to spit out toothpaste once or several times during brushing. If so, allow client to spit into emesis basin or sink and repeat Step 10 as needed.
14. Brush biting surfaces of molars with back-and-forth motion.
15. Brush tongue gently from back to tip.
16. Instruct or assist client to rinse mouth with water; hold emesis basin under client's chin with one hand if brushing in bed.
17. Allow client to spit into emesis basin or sink; wipe lips with towel.
18. Give client mouthwash (using a straw if needed); instruct client to swish it around and spit it out, cautioning client not to swallow mouthwash.
19. Allow client to spit into emesis basin or sink; wipe lips with towel.
20. Lubricate lips with lip balm.
21. Allow client to wash and dry hands.
22. Make client comfortable.
23. Place call device within reach, if applicable.
24. Remove, clean and store the equipment.
25. Remove and appropriately dispose of gloves.
26. Wash hands.
27. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Flossing Teeth

1. Wash your hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Wash hands.
7. Put on gloves.
8. Provide privacy.
9. Assist client to bathroom or an upright sitting position.
10. Break off an 18-inch piece of floss.
11. Hold floss between middle finger of each hand. Wrap ends of floss around first two fingers of each hand and anchor with thumbs.
12. Stretch floss between hands.
13. Insert floss between back molars on one side of mouth and work back and forth.
14. Move toward front of mouth and around to other side, flossing between each tooth on both upper and lower teeth. Use different section of floss after every second tooth.
15. Allow or assist client to rinse mouth with water; hold emesis basin under client's chin with one hand if flossing in bed.
16. Allow client to spit into emesis basin or sink; wipe lips with towel.
17. Lubricate lips with lip balm.
18. Allow client to wash and dry hands.
19. Make client comfortable.
20. Place call device within reach, if applicable.
21. Remove, clean and store the equipment.
22. Remove and appropriately dispose of gloves.
23. Wash hands.
24. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Administering Oral Hygiene to a Helpless or Unconscious Client

1. Wash your hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Wash hands.
7. Put on gloves.
8. Provide privacy.
9. Move client to side of bed that is easiest for you to work from.
10. Turn client's head toward you.
11. Spread towel under client's chin.
12. Moisten toothbrush with diluted mouthwash. Brush gum line and teeth in up-and-down motion on both sides.
13. Holding washcloth over emesis basin, moisten with diluted mouthwash.
14. Wipe teeth and gums with washcloth wrapped over tongue depressor.
15. Wipe client's lips with towel.
16. Apply lip balm to lips.
17. Make client comfortable.
18. Place call device within reach.
19. Remove, clean and store equipment.
20. Remove and appropriately dispose of gloves.
21. Wash your hands.
22. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Providing Denture Care

1. Wash your hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Wash hands.
7. Put on gloves.
8. Provide privacy.

9. Assist client to bathroom or an upright sitting position.
10. Ask client to remove dentures, or remove them yourself. Remove lower dentures first by grasping them between thumb and forefinger and lifting up; then remove upper dentures by placing thumb in center of front of dentures and tip of index finger at back of plate. Simultaneously pull down with thumb while pushing up with forefinger to break suction of plate against roof of mouth.
11. Place dentures in clean denture cup.
12. Provide water or diluted mouthwash to rinse mouth of food particles.
13. Allow client to spit into emesis basin or sink.
14. Have client wipe mouth with towel or tissue.
15. Fill clean sink half full of cool water or place clean washcloth on bottom of sink.
16. Brush dentures thoroughly using toothbrush and denture cleanser.
17. Rinse dentures with cool water and place them in clean cup.
18. If client wants to wear dentures, replace in mouth (upper plate first).
19. If client is not going to wear dentures, store in clean denture cup filled with appropriate solution.
20. Apply lip balm to lips.
21. Allow client to wash and dry hands.
22. Make client comfortable.
23. Place call device within reach, if applicable.
24. Remove, clean and store equipment.
25. Remove and appropriately dispose of gloves.
26. Wash hands.
27. Record pertinent observations and report unusual occurrences to supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 7: Oral Hygiene

Activity Sheet

1. List five purposes of oral hygiene.

   a. ____________________

   b. ____________________

   c. ____________________

   d. ____________________

   e. ____________________

2. List three observations a nurse assistant should make when providing oral hygiene.

   a. ____________________

   b. ____________________

   c. ____________________

3. List and describe two times when oral hygiene should be done/given.

   a. ____________________

   ____

   b. ____________________

   ____

4. What kind of strokes are used to clean the teeth?

   ____

5. What is flossing?

   ____

   ____

6. List five considerations specific to the care of dentures.

    a. ____

    b. ____

    c. ____

    d. ____

    e. ____

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedures, practice the following activities with a partner in the laboratory.

    a. Practice brushing your partner's teeth.

    b. Practice flossing your partner's teeth.

    c. Observe your partner's mouth for any of the signs described in Figure 7.1 of the lesson.

    d. Examine a pair of dentures and practice brushing them.

Lesson 8:
Nail Care

Objectives:

A. Identify the purposes of nail care.

B. Discuss general considerations in giving nail care.

C. Give fingernail care.

D. Give toenail care.

Key Terms:

- Orange stick
- Podiatrist

Fingernails and toenails continue to grow all through a person's lifetime and therefore must be cut and maintained regularly. Care of the nails should be part of the personal care provided to those clients who can no longer care for their nails on their own.

Purposes of Nail Care

The fingernails and toenails must be kept short, clean and free of rough edges. This prevents damage to the skin and provides a pleasant appearance. Ragged or long nails are a safety hazard to clients and to others. Keeping nails short and neatly trimmed may prevent cuts and scratches. If a client becomes agitated or combative, he or she may use long nails as a weapon. If nails are not kept clean, bacteria can grow in the dirt that accumulates under the nails. Infections could result, either locally in the nail bed or internally by depositing bacteria in scratches or in the mouth. The nurse assistant should observe the color and condition of the client's nails and surrounding skin when giving nail care. The color of the client's nail beds may show his or her respiratory condition. Normally, a client with good oxygenation has pink nail beds. In those clients who have lowered oxygen levels in their blood, the nail beds will be a bluish-purple. Nails may become black when an infection or injury is present.

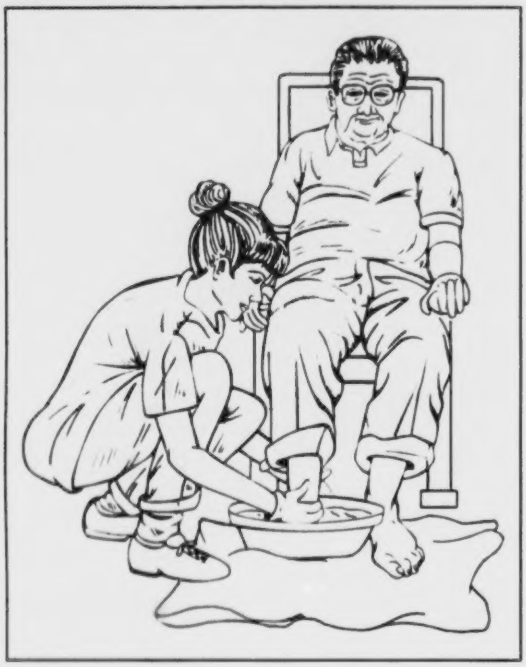
General Considerations in Giving Nail Care

Nail care includes cleaning, trimming and shaping nails. Clients' nails should be checked regularly for cleanliness and accumulated material should be removed from under the nails. An **orange stick**, a short, round stick with one end pointed and the other beveled, is best for cleaning under the client's nails. Nails should be trimmed and shaped as often as necessary to keep them short and smooth. The nails should also be checked for hangnails and ingrown nails. If either are present, notify the supervisor.

With inactive or elderly clients, the nails may become thick, brittle and difficult to trim. Soaking nails in warm water makes them softer and easier to trim. Toenails are usually thicker than fingernails, so they may require a longer soaking time to soften them, see Figure 8.1. Nail care can be incorporated into the bath procedure to take advantage of the client's softened nails.

Each health care facility will have its own policies regarding nail care. Some facilities restrict nurse assistants from trimming and shaping clients' toenails. If the policy allows the nurse assistant to trim nails, they should be trimmed straight across and not too close to the flesh. Clippers (as shown in Figure 8.2)

Figure 8.1 - Soaking Toenails

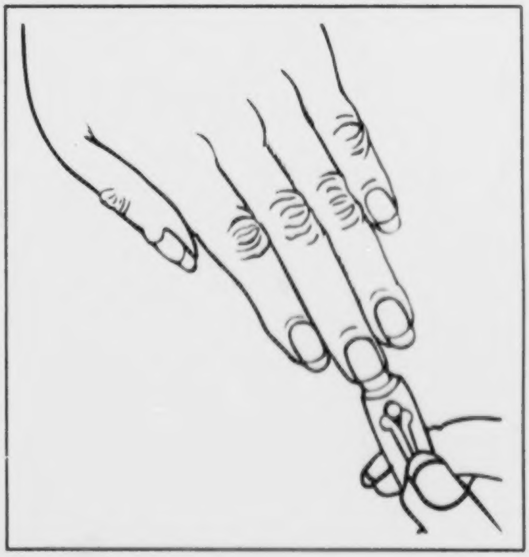


are easier and safer to use than scissors. After nails are clipped, an emery board can be used to smooth and shape the nails. A licensed nurse or **podiatrist**, a physician trained in foot care, is responsible for trimming the nails of clients with diabetes. These clients usually have poor circulation and heal slowly if injured. The following two procedures list the steps a nurse assistance would take when giving nail care to clients.

Steps of Procedure for Giving Fingernail Care

1. Wash your hands.
2. Assemble necessary supplies and equipment.
   NOTE: Equipment should include a supplementary light, if necessary, to provide a well-lit working area.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Wash hands.
7. Put on gloves, if appropriate.
8. a. If client is in bed, raise backrest. Place disposable bed protector under client's hands. Place towel on top of bed protector.
   b. If client is in a chair, lower overbed table; place table in front of client with disposable bed protector on top. Place towel on top of bed protector.
9. Place basin of warm, soapy water (approximately 105° Fahrenheit) on towel.
10. Soak client's fingers in warm, soapy water for five minutes. Either soak one hand at a time or both together.
11. Rinse hands with clear, warm water and dry with towel.
12. Remove basin from in front of client.
13. Place towel under client's dried hands.
14. Gently remove dirt from around and under each fingernail with orange stick. Use paper towel to clean orange stick.
15. Trim nails (if needed) straight across.
16. Shape and smooth nails with emery board.
17. Repeat steps 14-16 on other hand.

Figure 8.2 - Trimming Fingernails



18. Have client exercise hands by alternately stretching them and making a fist.
19. Massage lotion into client's hands.
20. Make client comfortable.
21. Place call device within reach, if applicable.
22. Remove, clean and store the equipment.
23. Remove and appropriately dispose of gloves (if being worn).
24. Wash hands.
25. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Giving Toenail Care

1. Wash your hands
2. Assemble necessary supplies and equipment.
   NOTE: Equipment should include a supplementary light, if necessary, to provide a well-lit working area.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Wash hands.
7. Put on gloves, if appropriate.
8. a. If client is in bed, raise bed backrest to a sitting position. Place disposable bed protector under client's feet. Place towel on top of bed protector.
   b. If client is in a chair, place a bath mat on the floor under client's feet.
9. Place basin of warm water on towel/bath mat.
10. Assist client in placing foot in basin if in bed or both feet in basin if in chair.
11. Soak client's foot/feet to soften the nails.
12. Wash foot/feet with soap and water.
13. Rinse and dry foot/feet.
14. Gently clean toenails with orange stick.
15. If toenails are long and need trimming, report to supervisor. If facility policy allows, trim nails straight across top of toe; be sure nail does not extend beyond toe.
16. Massage lotion into client's foot.
    NOTE: Repeat steps 10-16 for other foot if client is in bed.
17. Make client comfortable.
18. Place call device within reach, if applicable.
19. Remove, clean and store the equipment.
20. Remove and appropriately dispose of gloves (if being worn).
21. Wash hands.
22. Record pertinent observations and report unusual occurrences to supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 8: Nail Care

Activity Sheet

1. List four purposes of nail care.

   a. ____________________

   b. ____________________

   c. ____________________

   d. ____________________

2. List six considerations in giving nail care.

   a. ____________________

   b. ____________________

   c. ____________________

   d. ____________________

   e. ____________________

   f. ____________________

3. Describe an orange stick and how is it used in nail care?

   ____

   ____

4. Who should perform toenail care for a client with diabetes? Why?

   ____

   ____

   ____

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedures, practice the following activities with a partner in the laboratory.
    a. Practice giving fingernail care to your partner.
    b. Practice giving toenail care to your partner.
2. Interview a podiatrist or a nurse practitioner who works with clients with diabetes. Ask for information on the special nail care required for those clients.

Lesson 9:
Perineal Care

Objectives:

A. Identify the purposes of perineal care.

B. Discuss general considerations in giving perineal care.

C. Give perineal care to a female client.

D. Give perineal care to a male client.

E. Give perineal care to a client with a catheter.

Key Terms:

- Perineal care (peri care)
- Perineum
- Peribottles
- Foreskin

Perineal care (peri care) is the washing of a client's genital and rectal areas of the body. Clients may be modest about someone else washing this private area. The nurse assistant should display sensitivity and understanding of clients' emotions when performing this procedure.

Purposes of Perineal Care

Perineal care is done to cleanse this area of a client's body of secretions and accumulated waste products. The mucous membranes in the perineal area continually secrete a sticky substance to keep the membranes moist. Waste products not thoroughly removed during elimination also accumulate on the skin. The accumulation of secretions and waste products can lead to odors and potential infections. Left unwashed, skin and mucous membranes break down more rapidly. Perineal care prevents odors, infections and skin breakdown. It also promotes the client's general comfort and is sometimes performed after childbirth or surgery to promote healing.

General Considerations in Giving Perineal Care

The frequency of perineal care varies for each client. For most continent clients, a daily cleansing is sufficient. Incontinent clients should be given perineal care after each voiding or bowel movement. If the client has an indwelling catheter, perineal care is given at least once each shift and after each bowel movement. Clients recovering from childbirth or surgery involving the perineal area may receive perineal care routinely during the day and as needed by the client to promote healing and comfort. Odor also indicates the need for perineal care.

When performing perineal care, the area should be observed for any unusual or excessive discharge or odors. Redness or irritation of the tissues that can lead to skin breakdown and any rashes or sores should be noted.

Many clients will not know what the term "perineal care" means. The procedure should be explained to the client and his or her understanding and cooperation should be assured before starting the procedure. Since this is a private area, many clients will want to do their own care; they should be assisted to make sure all secretions and wastes are removed and no odors remain.

The procedure is completed from the cleanest area to the dirtiest. The stool is considered to have the most bacteria. The procedure is done from the front to the back for women and from the tip of the penis down the shaft to the scrotum and the rectum for men. The tissue of the perineal area, or **perineum**, is more fragile and sensitive to temperature than the rest of the body. It should be washed gently with water slightly cooler than bath water. Some facilities may have **peribottles**, squeeze bottles filled with cleaning solution, that the nurse assistant uses instead of washcloths to avoid irritating or damaging the perineal tissue (see Figure 9.1). Some facilities use commercial cleansing products. The nurse assistant should find out the facility's or agency's procedures before doing perineal care. If possible, the client should be in a supine position for perineal care. If this is not an option, care can be done with the client in a side-lying position, or the procedure can be incorporated as part of the bathing procedure. The client should be offered a bedpan or urinal before starting the procedure; warm water on the perineal area may stimulate the urge to urinate.

Figure 9.1 - Peribottle

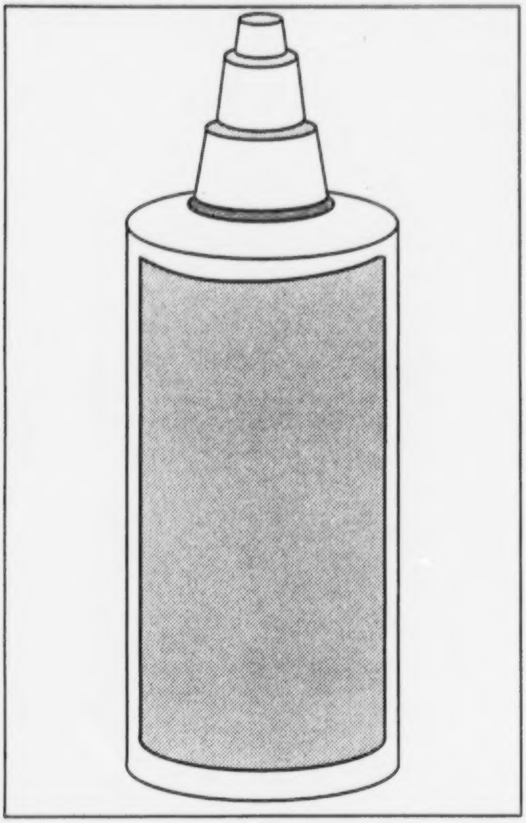
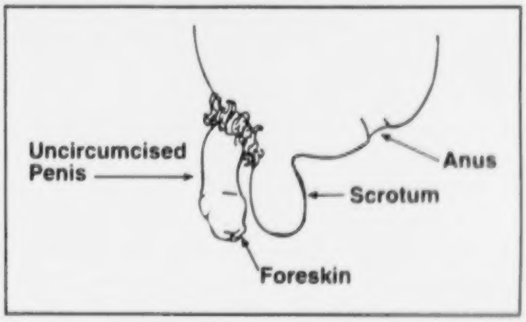


Figure 9.2 - Male Perineal Area



When giving perineal care to an uncircumcised man, the **foreskin**, the loose skin over the head of the penis, must be pulled back and the head of the penis washed (see Figure 9.2). The foreskin should be returned to its normal position. If the foreskin is left in a retracted position, it acts like a rubberband, causing swelling, pain and potential tissue damage. Gentle handling of the penis may prevent an erection from occurring. Perineal care can be completed even if an erection occurs. If the nurse assistant wishes, the client can be left alone and the procedure completed after the penis has softened.

Steps of Procedure for Giving Perineal Care to a Female Client

1. Wash hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Wash hands.
7. Put on gloves.
8. Provide privacy.
9. Place client in supine or side-lying position.
10. Place bed protector under buttocks.

11. Fill basin with warm water and bring it to bedside.
12. Cover client with bath blanket andpull back top linens to end of bed.
13. Fold bath blanket up to abdomen, exposing perineal area.
14. Have client flex and separate knees.
15. Gently wash inner area from front to back, using clean area of washcloth for each wipe.
16. Work outward through inner labia, outer labia, and groin creases, washing gently from front to back.
17. Rinse area well, starting with innermost area and proceeding outward.
18. Wash and rinse anal area.
19. Pat perineal area dry with towel.
20. Remove disposable bed protector and bath blanket.
21. Make client comfortable.
22. Place call device within reach, if applicable.
23. Remove, clean and store equipment.
24. Remove and appropriately dispose of gloves.
25. Wash hands.
26. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Giving Perineal Care to a Male Client

1. Wash hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Wash hands.
7. Put on gloves.
8. Provide privacy.
9. Place client in supine or side-lying position.
10. Place bed protector under buttocks.
11. Fill basin with warm water and bring it to bedside.
12. Cover client with bath blanket, and pull back top linens to end of bed.
13. Fold bath blanket up to abdomen, exposing perineal area. Pull bed spread up to thighs or cover thighs with towel.
14. Grasp penis around shaft and lift up.
15. Using circular motion, start at tip of penis and cleanse downward.
16. Rinse and dry with towel.
    NOTE: If foreskin has been retracted, pull back over end of penis.
17. Wash and rinse other skin areas between legs.
18. Wash and rinse anal area.
19. Pat perineal area dry with towel.
20. Remove disposable bed protector and bath blanket.
21. Make client comfortable.
22. Place call device within reach, if applicable.
23. Remove, clean and store equipment.
24. Remove and appropriately dispose of gloves.
25. Wash hands.
26. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Giving Perineal Care to a Client with a Catheter

1. Wash hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Wash hands.
7. Put on gloves.
8. Provide privacy.
9. Place client in supine position with legs apart.
10. Place bed protector under buttocks.
11. Cover client with bath blanket and pull back top linens to knees.

12. Check catheter and drainage bag for leaks, kinks, level of fluid in bag, character of urine, and secure attachment to bed frame.
13. Fold bath blanket up onto abdomen to expose perineal area.
    a. Separate labia of female client and gently wash around opening of urethra with soap and warm water.
    b. Gently pull back foreskin (if present) of male client and gently wash around opening of urethra with soap and warm water.
14. Wash catheter tubing from opening of urethra outward four inches or farther if needed without pulling on catheter.
15. Using fresh washcloth, continue washing and rinsing peri area according to steps of procedure for female or male client.
16. Remove bed protector and bath blanket.
17. Make client comfortable.
18. Place call device within reach.
19. Remove, clean and store the equipment.
20. Remove and appropriately dispose of gloves.
21. Wash hands.
22. Record pertinent observations and report unusual occurrences to the supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 9: Perineal Care

Activity Sheet

1. What is perineal care?

    ____

2. List three purposes of perineal care.

    a. ______________________________

    b. ______________________________

    c. ______________________________

3. Name two instances when perineal care is needed?

    a. ______________________________

    b. ______________________________

4. When should clients with incontinence be given perineal care?

    ____

5. When should a client with an indwelling catheter be given perineal care?

    ____

6. In what order should perineal care be done on a woman? What order should perineal care be done on a man?

    Female: ______________________________

    Male: ______________________________

7. In what position should the client be placed to complete perineal care?

    ____

    ____

    ____

8. What special measures are required when giving perineal care to an uncircumcised man?

___

___

Clinical/Laboratory Activity

1. After the instructor has demonstrated the procedures, practice complete perineal care on male and female perineal models for clients both with and without catheters.

Lesson 10:
Backrub and Skin Care

Objectives:

A. Identify purposes of the backrub and skin care.

B. Describe the observations to make while giving a backrub and skin care.

C. Discuss the general considerations in giving a backrub and skin care.

D. Give a backrub.

Key Terms:

- Blanch
- Mottled

The backrub is an enjoyable part of personal care. Sometimes backrubs are given purely to comfort and relax clients. At other times, they are a vital part of clients' personal care. A backrub can be crucial for keeping a bedridden client's skin stimulated and healthy.

Purposes of the Backrub and Skin Care

A backrub stimulates circulation and assists in preventing skin breakdown. It relaxes the muscles and causes general relaxation in clients. With the relaxation of muscles, a feeling of relief from tension also occurs. Communication flows more easily when a client feels relaxed, cared for and pampered. A backrub also allows the nurse assistant to observe the condition of a client's skin.

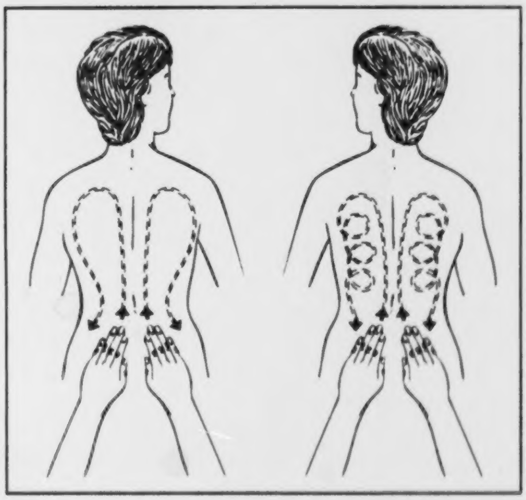
Observations While Giving a Backrub and Skin Care

A backrub provides a perfect opportunity for a nurse assistant to observe a client's skin. Since bedridden clients may spend a good portion of the day on their backs, this may be the first area to show signs of skin breakdown. Particular attention should be given to the skin over the bony prominences: the ridges of the spine, the blades of the scapulae, the ribs, the pelvic bones, and the coccyx. These areas should be observed for redness or irritation. Normal skin should **blanch**, or whiten, when pressed, then immediately return to its original color. Irritated tissue will not. **Mottled** skin, irregular bluish-purple patches that feel cool to the touch, may indicate that circulation has already been restricted or cut off to that area. Any break in the skin, such as cuts, abrasions, burns or sores should be noted and reported. Excessive dryness can also lead to skin breakdown. The nurse assistant should also look for rashes, bruises, swelling, lumps, or growths during a backrub.

General Considerations in Giving a Backrub and Skin Care

A backrub and skin care is given as part of the bathing procedure. It should also be given following the use of a bedpan when a client rolls over onto his or her side. A backrub is given before changing the position of a helpless client. Clients who must remain in bed are repositioned every two hours. If a client does not want a full backrub, the area around the bony prominences should be massaged gently. Giving a backrub at bedtime is a way to calm a client for a good night's sleep. A backrub should be offered to clients who need comfort or relaxation.

Figure 10.1 - Movement Patterns for Giving Backrubs



To decrease the friction of the hands rubbing against the skin, oil or lotion should be used during a backrub. The oil or lotion is warmed by placing the bottle in a pan of warm water or by squeezing some into the hands and warming with body heat. The skin of the ill and the elderly is very fragile; it must be handled gently to prevent bruising and tearing. Long, smooth strokes are the most relaxing to a client and the most stimulating to the skin. Circular strokes also help to loosen tight muscles as shown in Figure 10.1. The fingernails of the person giving a backrub should be short to prevent tearing of a client's skin. Gloves are not needed for the procedure unless a client has open wounds or draining sores.

Steps of Procedure for Giving a Backrub

1. Wash your hands.
2. Assemble necessary supplies and equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Wash hands.
7. Put on gloves, if applicable.
8. Provide privacy.
9. Assist client to move to side of bed from which it is easier for you to work. NOTE: Refer to Unit 6 for additional information on positioning clients.
10. Turn client onto side or assist him or her into prone position.
11. Place bath towel lengthwise close to client's back to protect bedding.
12. Expose client's back from neck to where buttocks meets thighs.
13. Wash, rinse, and dry back (if giving bed bath or if back is soiled).
14. Warm lotion; apply to entire back.
15. Using long, soothing strokes, start at base of spine and rub up center of back, around shoulders, and down sides of back and buttocks. Repeat four times.
16. Rub entire back, including buttocks, with small circular motions.
17. Repeat long strokes.
18. Pat dry with towel to remove excess lotion.
19. Make client comfortable.
20. Adjust bed covers.
21. Place call device within reach, if applicable.
22. Remove, clean and store the equipment.
23. Wash hands.
24. Remove and appropriately dispose of gloves (if being worn).
25. Record pertinent observations and report unusual occurrences to the supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 10: Backrub and Skin Care

Activity Sheet

1. List three purposes for giving backrubs and skin care.

   a. ____________________

   b. ____________________

   c. ____________________

2. What happens when the skin blanches? What is mottled skin?

   Blanching: ____________________

   ____

   Mottled skin: ____________________

   ____

3. Describe six observations of the skin to make during a backrub.

   a. ____________ d. ____________

   b. ____________ e. ____________

   c. ____________ f. ____________

4. List three times when a backrub and skin care should be given?

   a. ____________________

   b. ____________________

   c. ____________________

5. How can a nurse assistant warm oil or lotion used for a backrub?

   ____

   ____

6. List the two types of backrub strokes discussed and their purposes.

   a. ______________________________

   b. ______________________________

Clinical/Laboratory Activities

1. Survey the class and determine if any students do not like to receive backrubs. Find out why they do not like to receive them.

2. After the instructor has demonstrated the procedure, practice the activity with a partner in the laboratory. Have your partner describe how he or she feels about your ability to give a backrub determined by the relaxation and comfort he or she experienced.

Lesson 11: Bedmaking

Objectives:

A. Differentiate between the types of bedmaking.

B. Discuss key points in making a bed.

C. Make an occupied bed.

D. Make an unoccupied bed.

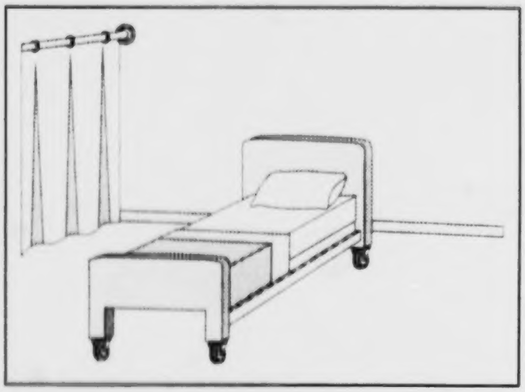
Key Terms:

- Open bed
- Surgical bed
- Closed bed
- Toe pleat
- Foot drop
- Draw sheet

Bedmaking is one of the procedures that provides comfort to the client. Wrinkled, soiled linens are uncomfortable and can cause infections and skin breakdown.

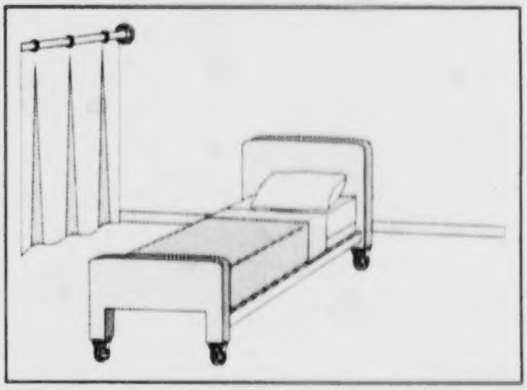
Types of Bedmaking

Figure 11.1 - Open Bed with Fanfolded Linen



An unoccupied bed is made when no one is in the bed. A client may be temporarily out of bed, or the bed may be vacant for an extended period of time. Unoccupied beds can be either open or closed. An **open bed** is one in which the top linens are fanfolded (see "Key Points in Bedmaking") to the bottom of the bed as shown in Figure 11.1. This indicates that the bed is ready for a client to use. Open beds are made only if a client is out of bed for a short period of time or right before a client is admitted in long-term and acute care. A client may be out of the bed if he or she is participating in an activity, having tests performed, or sitting in a chair next to the bed. An open bed is also made before a client returns from surgery. The bed prepared for a client returning from surgery is often called a **surgical bed** and has extra protective linen on it; it is left in the high position to accommodate the transfer of a client from a gurney. A **closed bed** is one in which the top linens are spread to cover the bottom linens to protect them from the accumulation of dust in the environment (see Figure 11.2). In long-term and acute care, a closed bed is made when a client is discharged, and it is left closed until a new client is admitted to that bed. It is also made this way when a client will be out of bed for an extended period of time. In long-term and home health care, closed beds are made when clients spend the

Figure 11.2 - Closed Bed



majority of their time out of bed during the day.

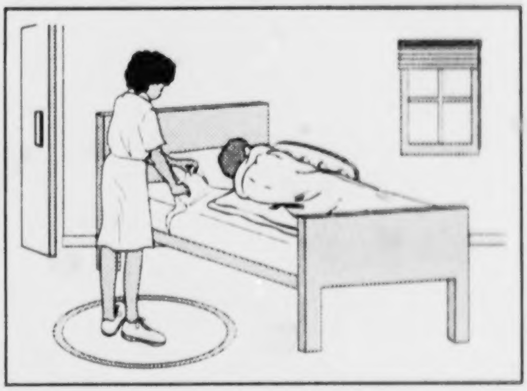
An occupied bed is made with a client in it, as shown in Figure 11.3. Occupied beds are more difficult to make than unoccupied beds, so they are only made when a client cannot be moved from the bed. Making the bed is done as part of a complete or partial bed bath, or when an incontinent client's sheets need changing.

Many types of beds are available for clients with special needs, such as those with fragile skin or those that require frequent turning and repositioning. Types of bedmaking may be different for these beds, and procedures should be reviewed before a bed is made. If a procedure is unclear, the nurse assistant should contact his or her supervisor.

Key Points in Bedmaking

Linen should be changed as needed to ensure cleanliness and comfort. Acute care facilities may have a policy of changing linens on beds daily, whether or not a bath is given or the linens are soiled. In long-term and home health care, linens are usually changed when a client has a bath and whenever the linens are soiled. In home health care, the client will have an established routine of how frequently sheets are to be changed.

Figure 11.3 - Making an Occupied Bed



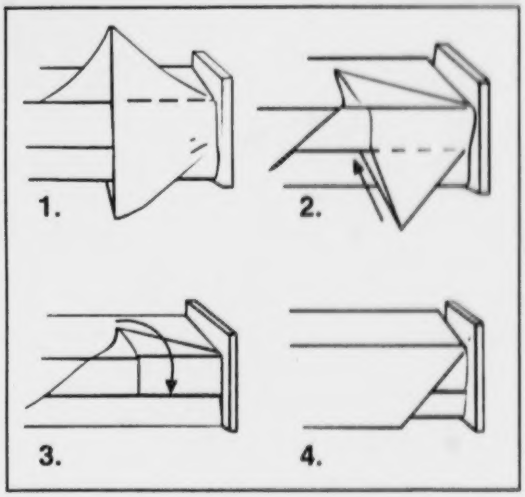
Many types of beds are used in health care. In most homes and in some long-term care facilities, standard beds will be present. Some facilities will have manual crank beds; others will have electric beds. The nurse assistant should remember to use good body mechanics when making a bed no matter what type of bed is used.

To save energy and time, linen should be stacked in the order of its use. This also prevents excessive handling of the linen. Making one side of the bed and then going to the other side to finish it is also more efficient.

To prevent the spread of infection, linens should not be shaken when making or stripping a bed. If linens are soiled, the soiled area should be rolled to the center and folded into the rest of the linens. Gloves are only necessary for this procedure when blood or body fluids have contaminated the linens that are to be removed from a bed. If gloves are used to strip the soiled linen from a bed occupied by a client that is incontinent or has exposed body secretions, they should be discarded and hands should be washed BEFORE working with the clean linen. Soiled linens should not come in contact with the nurse assistant's hands, face, or uniform. When dirty linens are carried, they should be placed in a bag or rolled and held away from the body. Dirty linens should NEVER be taken off of a bed and thrown on the floor. Before stripping the linens off of a bed and placing them in a soiled linen receptacle, the nurse assistant should check them for dentures, jewelry, eyeglasses, notepads, tissues and any other objects a client may have left in the bed.

A bed with tight, wrinkle-free sheets is a comfortable bed. Every effort must be made to keep the linens in that condition.

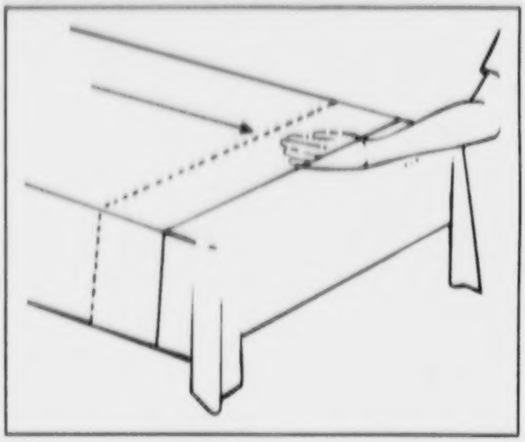
Figure 11.4 - How to Make a Mitered Corner



Fitted sheets sometimes slide off the corners of a bed, and they should be checked to make sure they are tight and secure. Even if a bed is not completely remade, the linens can be tightened by retucking the bottom and straightening the top when the client is out of bed for a short while. The corners of the linens should be mitered to keep them tight and to keep a bed neat and attractive. Figure 11.4 illustrates the process of making a mitered corner. Top linens, however, should not be so tight that circulation is impaired in the feet and legs. A **toe pleat,** an extra fold in both the top sheet and the bedspread, should be made to prevent restriction of circulation and **foot drop**, the flexion of the foot downward. (See Figure 11.5.)

Clients who are incontinent may need extra protective pads or **draw sheets**; sheets made of plastic or cotton placed crosswise in the middle of a bed over the bottom sheet to protect the bedding from soiling. A cotton draw sheet is used to cover a plastic draw sheet and can be used as a lift sheet (see Unit VI, Lesson 1) to move or turn weak or unconscious clients. They can be changed as necessary so the complete bed does not have to be remade.

Figure 11.5 - Making a Toe Pleat



Fanfolding is the way in which top linens are arranged on an open bed. The top sheet, blanket and bedspread are folded in half to the foot of the bed. Then the top sheet is folded back toward the head of the bed with the edge of the sheet meeting with the crease of the first fold. Fanfolded linens make it easier for a new or returning client to get into bed.

The home health aide will need to use the linen available in the home. Clients may have special ways of making their beds, and their wishes should be accommodated unless it creates a safety hazard. If the way a client wishes the bed to be made must be changed, the nurse assistant should explain the change and why it is necessary. Linen that is torn should not be used; body parts can become caught in a tear, and circulation can be restricted. Any type of plastic used to protect a bed should be covered with an extra sheet and should not come in direct contact with a client's skin. To minimize the amount of laundry, an unsoiled top sheet can be used as the bottom sheet when bed linens are changed.

Steps of Procedure for Making an Occupied Bed

1. Wash hands.
2. Gather linens and place in order to be used.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy.
7. Wash hands.
8. Put on gloves.
9. Raise bed to comfortable working position, with side rail opposite side you are working remaining up.
10. Lower back and knee rest until bed is flat, if client's condition allows.
11. Loosen top linens at foot of bed.
12. Fold bedspread to foot of bed, remove by grasping center, and place on back of chair if it is to be reused.
13. Remove blanket according to step 12, if applicable.
14. Ask client to hold top sheet in place or tuck it under client's shoulders.
15. Turn client to side of bed away from you, keeping pillow under head.
16. Loosen bottom bedding, rolling linens to client's back.
17. Remove and appropriately dispose of gloves.
18. Raise bed rail.
19. Wash hands.
20. On same side, lower bed rail.
21. Place mattress pad on bed lengthwise with fold in center.
22. Place bottom sheet lengthwise with fold in center and lower edge of sheet even with foot of mattress.
23. Tuck sheet under head of mattress, miter corners, and tuck well under side of mattress.
24. Fanfold bottom sheet and mattress pad close to client's back.
25. Place plastic draw sheet or protective pad on middle third of mattress (if needed), and tuck in near side fanfolding rest to client's back.
26. Center cotton draw sheet over plastic draw sheet or protective pad (if needed), and tuck in near side fanfolding rest to client's back.
27. Raise bed side rail; assist client in rolling over linen and moving to clean side of bed.
28. Move pillow, keeping it under client's head.
29. Go to opposite side of bed; lower side rail.
30. Pull through all bottom linen; remove and place in bag or soiled linen receptacle.
    NOTE: If linens are soiled with secretions, gloves should be worn to remove soiled linen, then gloves are discarded and hands washed before clean linen is touched.
31. Pull clean mattress pad toward edge of bed and tuck under mattress.
32. Pull clean bottom sheet toward edge of bed. Tuck it under mattress at head of bed and make mitered corner.
33. Tuck bottom sheet under mattress along side of bed.
34. Pull plastic draw sheet or protective pad and cotton draw sheet; tighten and tuck under mattress.
35. Assist client to center of bed.
36. Place top sheet over soiled top sheet; ask client to hold clean sheet or tuck clean sheet only under client's shoulders.
37. Remove soiled top sheet by pulling it out from under clean sheet and place in soiled linen receptacle.
38. If blanket is used, place it over top sheet; place bedspread over blanket even with top sheet.
39. Make toe pleat in top linen at foot of bed by folding over two inches of linen where client's feet are.
40. Tuck sheet, blanket, and bedspread at foot of bed under mattress and miter corners on each side.
41. Change pillowcase and place pillow under client's head.

42. Lower bed, recess bed cranks, and put both side rails up, if applicable.
43. Place call device within reach, if appropriate.
44. Place bagged, dirty linen in appropriate receptacle.
45. Wash hands.

Steps of Procedure for Making an Unoccupied Bed

1. Wash hands.
2. Gather linens and place in order to be used.
3. Identify and greet client, (if client is in room).
4. Identify self.
5. Explain what you are going to do.
6. Wash hands.
7. Put on gloves.
8. Position bed flat, raise to comfortable working height, and lower bed rails. NOTE: This step will not be possible if bed is standard piece of furniture.
9. Strip pillowcase off pillow and place pillow out of way.
10. Strip bed and place linen in soiled linen receptacle.
11. Wash and dry mattress, if soiled.
12. Remove and appropriately dispose of gloves.
13. Wash hands.
14. Place mattress pad on bed and pull smooth.
15. Unfold bottom sheet on bed to full length, with bottom hem at bottom edge of mattress.
    NOTE: For fitted sheets, both corners should be secured onto mattress.
16. Tuck bottom sheet under head of mattress and miter corner.
17. Tuck in bottom sheet along side of bed working from head to foot.
18. Place plastic draw sheet or protective pad on middle third of mattress (if needed); tuck in near side only.
19. Center cotton draw sheet over plastic draw sheet or protective pad (if needed) and tuck in near side.
20. Place top sheet, halved, on full length of bed, with hem at edge of head end of mattress.
21. Unfold top sheet.
22. Place blanket over top sheet centered on bed and about eight (8) inches down from edge of top sheet.
23. Place bedspread (centered) over top sheet and blanket, leaving enough bedspread to cover pillow at top edge.
24. At foot of bed, miter corners of bottom sheet only and tuck under foot of bed.
25. Gather one side of pillowcase from open end to seamed end.
26. Grasping seamed end of case, allow gathers to fall back over your wrist.
27. Grasp edge of pillow through pillowcase and, holding it securely, work gathered pillowcase down over pillow.
28. Place pillow on near half of bed with open end of pillowcase away from doorway.
29. Going to other side of bed, fold back each piece of linen.
30. Pull mattress pad smooth and tuck under mattress from head to foot.
31. Pull bottom sheet tight (or if using fitted sheet, pull corners down over mattress); tuck under head of mattress; miter corner; tuck in remainder of sheet from head to foot.
32. Tighten plastic draw sheet or protective pad; tuck in middle first, then top ⅓, and finally bottom ⅓.
33. Repeat step 32 with cotton draw sheet.
34. Pull top sheet, blanket, and bedspread straight; tuck them under foot of mattress.
35. Miter corners of top sheet, blanket and bedspread together; allow sides to hang free.

36. Place pillow in center of head of bed; pull bedspread over if bed is to be closed or fanfold all top linens to foot of bed if bed is to be open.
37. Lower bed and recess bed cranks, if applicable.
38. Raise bed rail on side away from entry.
39. Place call device within reach, if appropriate.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 11: Bedmaking

Activity Sheet

1. Describe the following types of beds.

Open bed: ______________________________

____

Surgical bed: ______________________________

____

Closed bed: ______________________________

____

2. What are two ways the nurse assistant can save time and energy when making a bed?

a. ______________________________

b. ______________________________

3. What are two precautions a nurse assistant should take to prevent the spread of infection when making a bed?

a. ______________________________

b. ______________________________

4. What is a toe pleat? Why is it used?

____

____

5. What are two considerations when making a bed in a client's home?

a. ______________________________

____

b. ______________________________

____

Clinical/Laboratory Activity

1. After the instructor has demonstrated the procedures, practice making an occupied and an unoccupied bed in the laboratory with a partner.

Lesson 12: The Client's Environment

Objectives:

A. Identify elements of the client's environment.

B. Discuss general considerations in maintaining the client's environment.

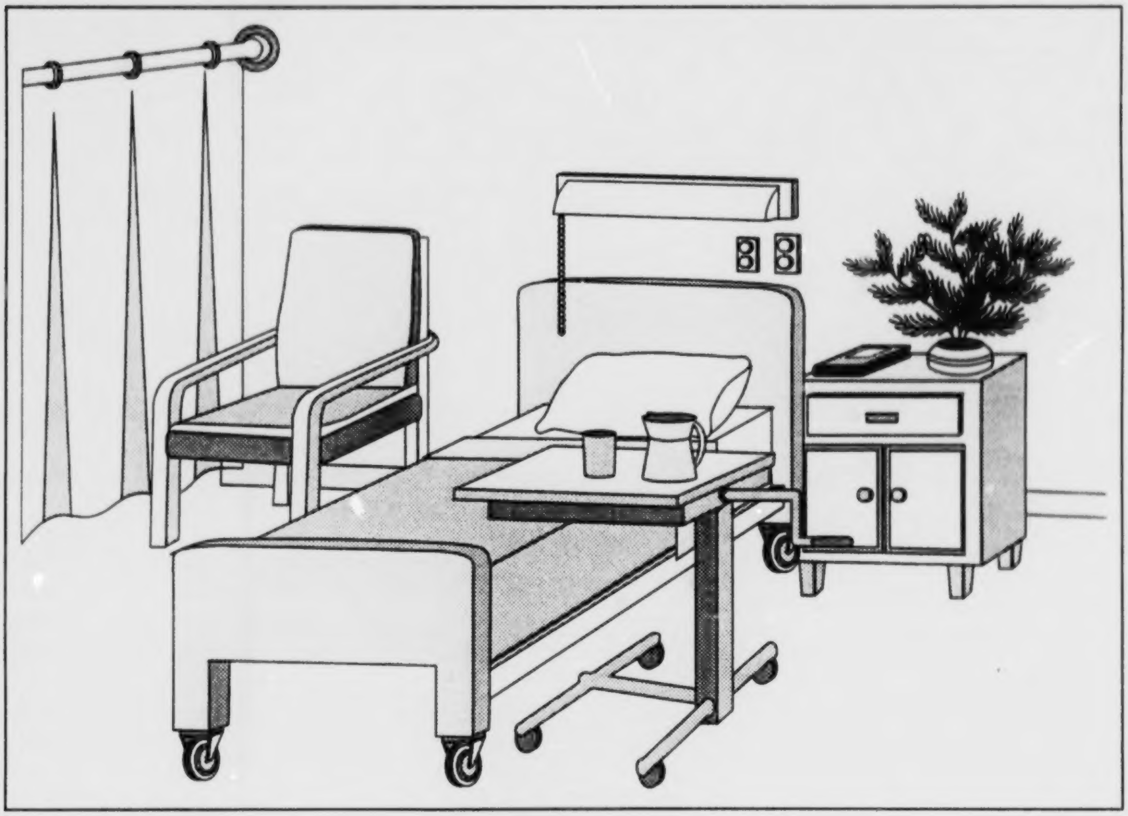
C. Maintain the client's environment.

A client's environment will change depending on whether he or she is a client in a health care facility or at home. While a bedroom may be similar to a client's room in a facility, other parts of the environment will be different. The nurse assistant in any setting will need to maintain the environment to prevent safety hazards and to ensure infection control.

Elements of the Client's Environment

In acute care, the client's environment consists of a hospital bed, a bedside table, an overbed table, a call device, a light, a chair, a closet or storage area for clothing, and usually a television. Figure 12.1 is an example of a client's environment. The long-term care facility has the same items along with any personal furniture or other items, such as pictures, plants, etc., that the resident is allowed to bring to the facility. The home health aide usually works in only two areas of a home, a

Figure 12.1 - The Client's Environment



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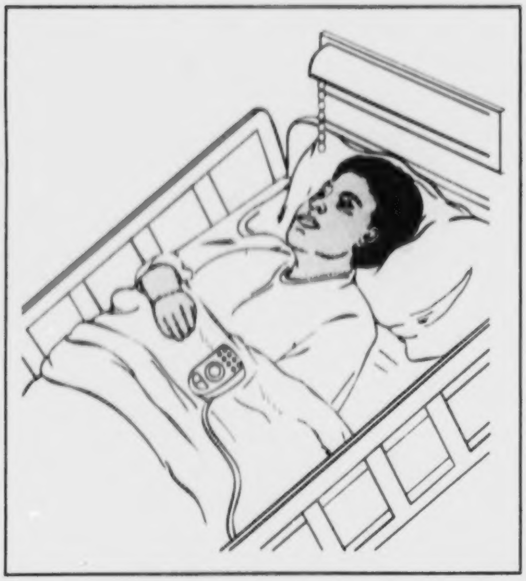
client's bedroom and bathroom. However, he or she may be required to provide private duty skills, such as cleaning, fixing meals and maintaining the home.

General Considerations in Maintaining the Environment

Health Care Facility Setting

In a health care facility, the housekeeping staff maintains the general cleanliness of the environment. The nurse assistant, however, should clean furniture surfaces and wipe up spills immediately for infection control and safety. All equipment and clients' personal items should be neatly stored when not in use. Furniture should be positioned for a client's use and for safe movement of everyone who enters the room. If furniture is moved for a procedure, it should be moved back when the procedure is completed. The call device should be positioned within easy reach for a client, as shown in Figure 12.2. All call devices should be answered promptly.

Figure 12.2 - Proper Position of a Call Device



Personal Care, page 5.84

A client should be kept supplied with fresh water, ice, drinking cups, tissues, and straws.

Fresh towels and washcloths should be placed in the bathroom as needed. Soap dispensers and paper towel holders should be checked regularly; if empty or low, the person who is responsible for them should be informed. If a client has received numerous cards, the cards should be placed so that the client can enjoy them without hindering care-giving. Keeping flowers watered and removing any dead ones may be a nurse assistant's responsibility.

Temperature, air circulation and lighting must also be considered when maintaining a client's environment. Temperature should be between 70°-75° F. It may feel slightly warm, even hot to staff, but may be comfortable to ill clients who are more sensitive to cooler air and who must remain in the room while others come and go. Individual thermostats may not be available; maintenance or environmental services may need to be contacted to change room temperature. Curtains and screens can be used to shield clients from drafts. The facility's air flow system usually controls the circulation of air; however, some facilities may have windows that open to circulate more air. Lighting should be sufficient to allow both a client and the nurse assistant to accomplish their tasks. If extra lights are brought into a room to spotlight tasks needing greater illumination, they should be returned to storage after the procedure is completed. If clients in long-term care facilities bring in their own lamps, maintenance may need to approve their use. Contact with a light bulb that has been on can cause burns; therefore, any light bulb in the environment should have a protective shield or shade. The nurse assistant should protect a client or himself or herself from coming into contact with a light bulb that has been on.

All health care workers should take responsibility for keeping the noise level at a minimum. Speaking quietly, handling equipment carefully, and keeping the television or radio volume turned down will help to keep the noise at a tolerable level for everyone who shares the environment. Equipment should be maintained, oiled and repaired to prevent squeaking and rattling as it is being pushed in the halls.

Home Health Care Setting

Each client's home is a unique environment. The principles for maintaining a facility can also be used in a home. Each client has the right to keep his or her home environment the way they wish, although it may not meet accepted nursing standards. The home health aide must respect the wishes of a client and accept the environment as each client chooses to keep it. For example, the home environment may appear cluttered as a client gathers familiar objects around himself or herself. The home health aide should leave items as the client wishes as long as the items do not cause a safety hazard or interfere with care-giving.

If the home health aide is responsible for light housekeeping, he or she should seek instructions about the client's preferences. The home health aide may often feel a need to rearrange items to make them more organized and tidy. Nothing should be moved without the client's permission. No call system is generally available in a home, thus the home health aide will need to devise a system by which the client can communicate a need if the aide is out of the room. Temperature, air circulation and lighting should be maintained according to the client's desires, not what the home health aide feels is best.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

After you have completed the activity sheets, you may take the written evaluation for this unit. A score of at least 80 percent indicates you may proceed to the next unit.

Lesson 12: The Client's Environment

Activity Sheet

1. Identify six elements that may be found in a client's environment.

   a. ______________________ d. ______________________

   b. ______________________ e. ______________________

   c. ______________________ f. ______________________

2. List four responsibilities that a nurse assistant may have for maintaining a client's environment in a health care facility.

   a. ____

   b. ____

   c. ____

   d. ____

3. List two responsibilities that a home health aide may have for maintaining a client's environment in a home health setting.

   a. ____

   b. ____

4. What is the appropriate range of temperature for a client's room?

   ____

5. Why should the nurse assistant NOT change the temperature in a client's room unless requested?

   ____

   ____

   ____

6. List two ways a nurse assistant can keep the noise level to a minimum?

   a. ____

   b. ____

Clinical/Laboratory Activities

1. Visit a health care facility and make a list of all the items present in a client's room. How does your list compare to the list given in your lesson? Why might some things be missing? Why might extra items be present?
2. Talk to a nurse assistant in a health care facility and find out what he or she does to help maintain the environment.
3. Determine whether it might be harder or easier to maintain a home environment rather than a facility environment. Make a list of reasons you think it is either harder or easier. Share your thoughts in a group discussion.

Unit Checklist

Student Name ______________________________ Overall Unit Rating ________

Activity Sheet: Introduction to Personal Care Rating ________

Comments: ____

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Activity Sheet: Eyeglasses, Hearing Aids and Prostheses Rating ________

Comments: ____

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Skill Sheet: Insert or Remove a Hearing Aid Rating ________

Skill Sheet: Place and Remove Eyeglasses Rating ________

Activity Sheet: Dressing and Undressing Rating ________

Comments: ____

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Skill Sheet: Assist a Client to Dress Rating ________

Skill Sheet: Assist a Client to Undress Rating ________

Activity Sheet: Bathing Rating ________

Comments: ____

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____

Skill Sheet: Give a Complete Bed Bath Rating ________

Skill Sheet: Give a Tub Bath Rating ________

Skill Sheet: Give a Whirlpool Tub Bath Rating ________

Skill Sheet: Give a Shower Bath Rating ________

Activity Sheet: Shaving Rating ________

Comments: ____________________

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Skill Sheet: Shave a Client with a Safety Razor Rating ________

Skill Sheet: Shave a Client with an Electric Razor Rating ________

Activity Sheet: Hair Care Rating ________

Comments: ____________________

____

____

Skill Sheet: Comb or Brush Hair Rating ________

Skill Sheet: Give a Tub or Shower Shampoo Rating ________

Skill Sheet: Give a Bed Shampoo Rating ________

Activity Sheet: Oral Hygiene Rating ________

Comments: ____________________

____

____

Skill Sheet: Assist a Conscious Client with Oral Hygiene Rating ________

Skill Sheet: Floss Teeth Rating ________

Skill Sheet: Administer Oral Hygiene to a Helpless or Unconscious Client Rating ________

Skill Sheet: Provide Denture Care Rating ________

Activity Sheet: Nail Care Rating ________

Comments: ____________________

____

____

Skill Sheet: Give Fingernail Care Rating ________

Skill Sheet: Give Toenail Care Rating ________

Activity Sheet: Perineal Care Rating ________

Comments: ____

____

____

Skill Sheet: Give Perineal Care to a Female Client Rating ________

Skill Sheet: Give Perineal Care to a Male Client Rating ________

Skill Sheet: Give Perineal Care to a Client with a Catheter Rating ________

Activity Sheet: Backrub or Skin Care Rating ________

Comments: ____

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Skill Sheet: Give a Backrub Rating ________

Activity Sheet: Bedmaking Rating ________

Comments: ____

____

____

Skill Sheet: Make an Occupied Bed Rating ________

Skill Sheet: Make an Unoccupied Bed Rating ________

Activity Sheet: The Client's Environment Rating ________

Comments: ____

____

____

Written Unit Evaluation Score ________

Additional Comments: ____

____

____

Teacher Signature ______________________________ Date ______________

Student Signature ______________________________ Date ______________

Unit VI

Restorative Nursing

The ability to move is one of the activities of daily living. Most people are unaware of the motions their bodies go through when getting out of bed in the morning, performing hygienic measures, dressing, eating, and moving throughout the day. Many health care clients have lost part or all of these abilities. To restore mobility to the client, the nurse assistant must help the client move, or he or she must move the client completely from one position to another. This unit describes all the ways in which the nurse assistant can aid in the mobilization of clients.

Unit Lessons

Moving and Positioning the Client

Transferring the Client

Ambulation

Range of Motion Exercises

Lesson 1:
Moving and Positioning the Client

Objectives:

A. Discuss general considerations in moving and positioning clients.

B. Identify aids to moving and positioning clients.

C. Assist or raise a client's head and shoulders.

D. Move a helpless client to the head of the bed.

E. Move or assist a client to the head of the bed.

F. Move a client to one side of the bed.

G. Turn a client to his or her side.

H. Turn a client to a prone position.

Key Terms:

- Alignment
- Lift or draw sheet
- Trapeze
- Bolsters
- Wedges
- Sandbags
- Footboard

Count how often you move a body part or change positions within five minutes. Imagine what it is like not to be able to move when you wish. Strong muscle groups in a body part may contract or draw into a fixed position called a contracture. This may be caused by disease processes that weaken muscle and nerve function or when the body is left in one position for a long time. The nurse assistant can help clients maintain normal body function by helping them move and by positioning them properly. This will also assure comfort, prevent pressure on one area of the body, and prevent a contracture.

General Considerations in Moving and Positioning a Client

A lesson on body mechanics is presented in the *Health Care Assistant Core* curriculum. That lesson also describes the seven basic positions used for positioning clients. Nurse assistants should practice good body mechanics when moving and positioning clients to prevent injury to themselves or to clients. Before attempting to practice the procedures for moving and positioning clients, review the basic techniques of moving heavy objects.

Clients should do as much as possible for themselves. They need exercise to keep the body systems functional and even the little amount of exercise involved in rolling from their backs to their sides is better than no exercise at all. The nurse assistant should be patient when clients are attempting to do their own moving and positioning, as they may be slow. It is tempting to help clients move to save time, but this would be less beneficial to the clients.

Determine if the client needs help before attempting to move or reposition. Clients can be heavy and if they are unable to help, their "dead weight" can be difficult to maneuver. The nurse assistant should get help before moving or positioning heavy clients. Assistance may also be needed when moving a client with an IV, a catheter, or a feeding tube, so that the tubes are not pulled, kinked, or misplaced by the activity.

When moving a client, give the most support to the heaviest part of the client's body. The nurse assistant should hold the client close to his or her body for the best control during the move. Use smooth and steady movements when lifting, moving, and positioning. When moving the client to a piece of equipment or furniture, make sure to position it against a solid surface to prevent it from moving during the activity. Gloves are worn during any moving and positioning that involves direct or indirect contact with body fluids or wet linens.

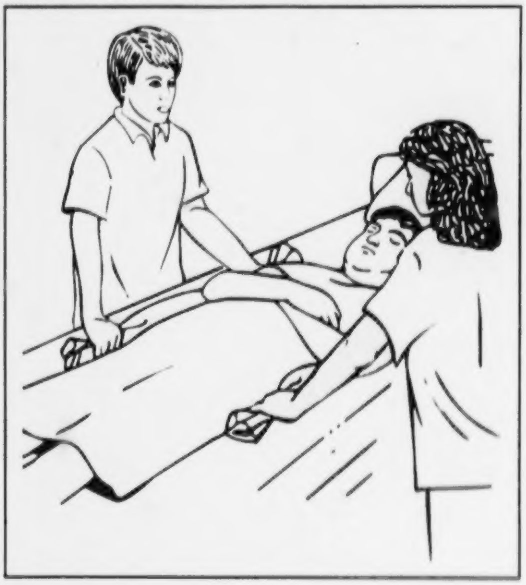
The client's body should be in good **alignment**, which is when body parts are positioned so that the body can function at its best and is most comfortable. Improper positioning may delay the client's gaining independence or maximum functional capacity.

Aids to Moving and Positioning Clients

A **lift** or **draw sheet** can be used to assist in moving and positioning a client. A lift sheet is a standard bedsheet folded, usually in half, and placed under the client's trunk, from shoulders to hips. Lifting one side of the sheet will roll the client to the side. Two people, positioned on each side, can use the sheet to fully lift the client. Figure 1.1 shows the positioning of a client by two people using a lift sheet.

A **trapeze** is a triangular grab bar that hangs above the client's chest within the client's reach. A client who can help with moving and positioning can use a trapeze. The client grasps the bar to help with moving up in bed or to lift the trunk of the body off the bed.

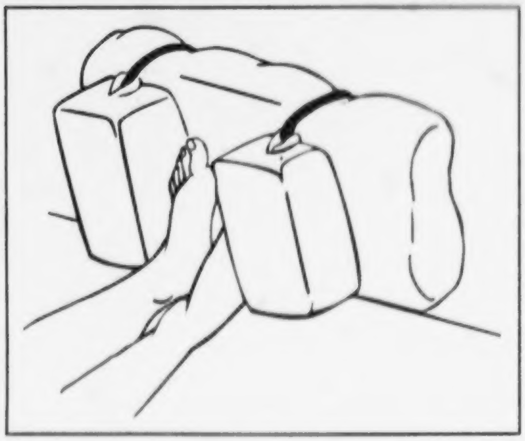
Figure 1.1 - Using a Lift Sheet



Positioning aids can be as simple as standard bed pillows. Place pillows to support positioning of a body part, or place pillows behind the back to support a client lying on his or her side. Rolled towels and blankets can immobilize or hold a body part in position. Foam-filled **bolsters** or **wedges** are used to elevate the trunk or other parts of the body. These can also be used to prop a client on his or her side. Some facilities use **sandbags** to immobilize a body part. Sandbags are much heavier and harder for a client to dislodge accidentally. Another aid, a **footboard** (a padded, upright board), can be placed at the foot of the bed to give the client a solid, flat surface against which to rest his or her feet. It also prevents footdrop, (see Figure 1.2). Physical or occupational therapists may make or suggest additional positioning aids, such as hand and foot splints.

Side rails on beds can be used both for safety and to help the client to turn. With the side rail in the raised position, the client can help with positioning by grasping the rail. The rail may also be

Figure 1.2 - A Footboard Positioning Aid



raised on the side to which the client is moving to prevent the client from accidentally rolling out of bed. However, the side rail is considered a restraint and after the client is in the proper position, the rail should be placed as the client wishes or as ordered by the physician.

Assisting or Raising Clients' Heads and Shoulders

When preparing a client for a meal in bed or positioning the client for leisure time, the nurse assistant may need to assist the client in raising his or her head and shoulders. The following procedure outlines the steps a nurse assistant would take in performing this task.

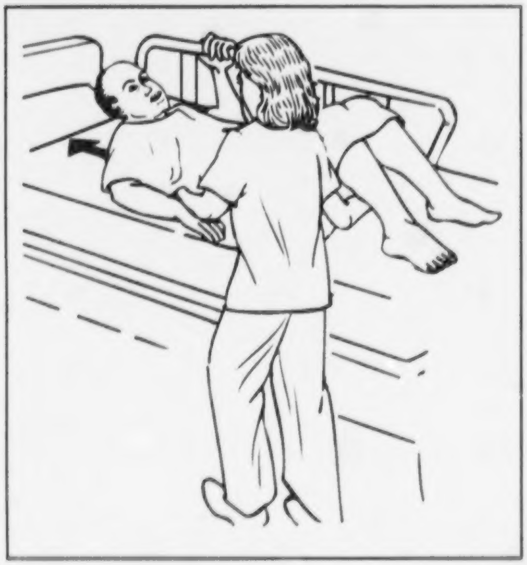
Steps of Procedure for Assisting With or Raising Client's Head and Shoulders

1. Wash your hands.
2. Identify and greet client.
3. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Raise bed to a comfortable working height.
7. Lock wheels on bed.
8. Make certain far side rail is raised.
9. Lower side rail near you.
10. Face the head of the bed with your feet shoulder width apart, one foot slightly ahead of the other.
11. Instruct client to put near arm under your near arm and behind your shoulders with hand on your shoulder.
    NOTE: If you are standing at the client's right side, his or her right hand will be on your right shoulder. If you are on his or her left, the client's left hand will be on your left shoulder.
12. Put your arm under the client's arm with your hand on his or her shoulder. Thus, you will lock arms with the client.
13. Put your other arm under the client's neck and shoulders and help him or her to raise up.
14. While keeping your arm locked with the client's, use your other arm to adjust the pillow.
15. Ease the client down with the locked arm while supporting client's neck and shoulders with other arm.
16. Make certain client is in good body alignment.
17. Lower bed to lowest position.
18. Raise side rail near you if ordered.
19. Make the client comfortable.
20. Place call device within reach.
21. Wash your hands.

Moving or Assisting Clients to the Head of the Bed

Often a client will slip too far down on the bed and will need help to move up. There are two methods frequently used to move the client up that are determined by the client's ability to help. If the client is small or needs little assistance, the nurse assistant may be able to put his or her arms under the shoulders and knees of the

Figure 1.3 - Moving/Assisting a Client to the Head of the Bed



client and slide the client, being sure to use good body mechanics as illustrated in Figure 1.3. If the client is large or totally dependent, two caregivers should use a lift sheet to move the client.

When moving the client, the nurse assistant must be careful not to pull the client in such a way that the skin receives friction burns from the sheets. This is particularly a problem if the sheets are damp and the client's skin sticks to them. The nurse assistant must be sure the client can slide freely before trying to move the client. Placing a sheet under the client will aid in moving the client.

The following two procedures list the steps a nurse assistant would take when moving or assisting dependent and non-dependent clients to the head of a bed.

Steps of Procedure for Moving Helpless Client to the Head of the Bed

1. Ask another nurse assistant to work with you.
2. Wash your hands.
3. Identify and greet client.
4. Identify self and other nurse assistant.
5. Explain what you are going to do.
6. Provide privacy.
7. Raise bed to a comfortable working height.
8. Lock wheels on bed.
9. Lower backrest.
10. Lower side rails.
11. If the client has any tubing that is pinned to the bedding, unfasten the tubing so that it will move freely with the client.
12. Move pillow to headboard so client does not hit head when moving up.
13. Nurse assistants should stand on opposite sides of the bed.
14. Position a lift sheet/folded regular sheet under shoulders and hip area, if one is not already present.
15. Each nurse assistant should roll edges of the sheet toward the client's body and grasp the rolled sheet with his or her hands at the client's shoulders and at the mid-hip area.
16. Point your feet in the direction that you are moving the client; bend knees, keep back straight.
17. On the count of three, each nurse assistant lifts the client up off the surface of the bed and toward the head of the bed while shifting weight from the back foot to the front foot. Lower client to bed surface.
18. Replace pillow.
19. Adjust backrest for comfort.
20. Lower bed to lowest position.
21. Raise side rails if ordered.
22. Make the client comfortable.
23. Place call device within reach.

24. Fasten tubing if unpinned while moving the client.
25. Adjust bedding.
26. Wash your hands.

NOTE: The home health aide usually works alone. A care giver may be present in the home who could help with this procedure. If no other person is available to help, this procedure should not be used in the home health setting.

Steps of Procedure for Moving or Assisting Client to the Head of the Bed

1. Wash your hands.
2. Identify and greet client.
3. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Raise bed to a comfortable working height.
7. Lock wheels on bed.
8. Lower backrest.
9. Lower side rail on the side you are working.
10. If the client has any tubing that is pinned to the bedding, unfasten the tubing so that it will move freely with the client.
11. Move pillow to headboard so client does not hit head when moving up.
12. Help client bend knees and press feet firmly against the mattress.
13. If client is able, have him or her grasp head of bed or trapeze bar (if present above the bed), otherwise the client should cross arms over his or her chest.
14. Slide one arm under the client's shoulders and the other under the thighs.
15. Stand facing head of the bed with your feet shoulder width apart. Front foot should be slightly ahead of the back foot.
16. On the count of three, have the client push with feet and you shift your weight from your back leg to your front leg as you slide the client up in the bed.
17. Replace pillow.
18. Adjust backrest for comfort.
19. Lower bed to lowest position.
20. Raise side rails if ordered.
21. Make the client comfortable.
22. Place call device within reach.
23. Fasten tubing if unpinned before moving the client.
24. Adjust bedding.
25. Wash your hands.

Moving Clients to One Side of the Bed and Turning Clients to One Side

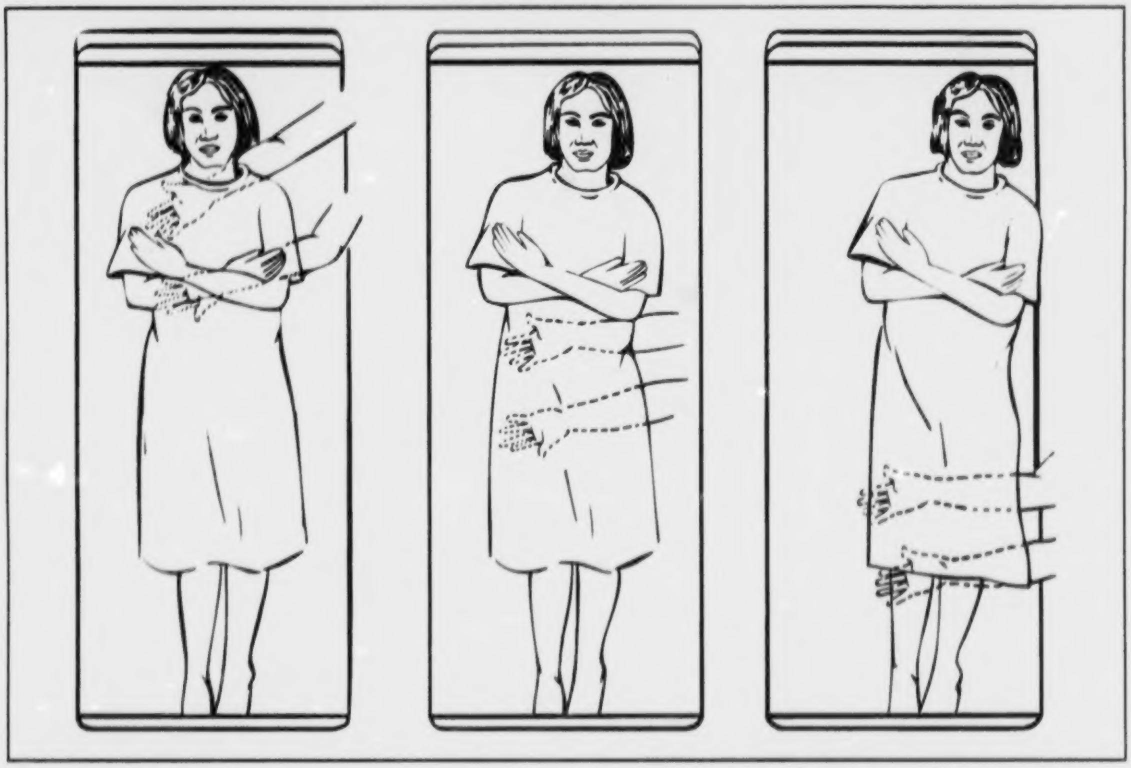
Many persons have no difficulty lying flat on their backs or propped up in bed; however, there are some situations that make these positions difficult or uncomforatble for clients.

An elderly client with a stooped posture is usually unable to lie flat and must have two or three pillows under his or her head. This type of client may tolerate side-lying better than other positions. It is a good idea to ask the client if lying on his or her back is a problem.

To help a client who can move independently turn to one side in a bed, the nurse assistant must first help the client move to one side of the bed, (see Figure 1.4). This allows the client room to roll onto his or her side without getting too close to the edge of the bed. If the client is unable to help, a lift sheet placed under the client's body can be an asset.

In the side-lying position, the client may need assistance in positioning the lower arm and shoulder for comfort; the shoulder

Figure 1.4 - Moving a Client to One Side of the Bed



and arm should remain in front of the body. The lower leg may be straight or flexed. The upper leg should be flexed if the lower leg is straight and vice versa. Pillows should be placed under the client's head and between the legs. The pillow between the legs helps maintain comfortable body alignment and prevents skin irritation that can occur when bare legs are rubbed together for a long period of time.

For clients with a nonfunctional side, a handroll or rolled washcloth should be placed in the client's hand with the thumb placed in opposition to the fingers. Handrolls are used to keep the hand slightly flexed and to prevent the fingers from curling into the palm.

The following two procedures list the steps a nurse assistant would take when moving clients to one side of a bed and turning clients to one side.

Steps of Procedure for Moving Client to One Side of the Bed

1. Wash your hands.
2. Identify and greet client.
3. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Raise bed to a comfortable working height.
7. Lock wheels on bed.
8. Lower backrest.
9. Lower side rail on the side you are working.
10. If the client has any tubing and it is pinned to the bedding, unfasten the tubing so that it will move freely with the client.
11. Remove pillow and loosen top sheets without exposing the client.
12. Stand on the side of the bed toward which you intend to move client.

13. Position front leg with one knee against the bed and the other leg (back) approximately two feet behind the front leg.
14. Slide both arms under the client's back to his or her far shoulder, then slide the client's shoulders toward you on your arms by shifting your body weight from the front leg to the back leg.
    NOTE: Keep your knees bent and your back straight as you slide the client.
15. Slide both your arms as far as you can under the client's buttocks and slide his or her buttocks toward you.
16. Place both your arms under the client's feet and slide them toward you on your arms.
17. Replace pillow.
18. Adjust backrest for comfort.
19. Lower bed to lowest position.
20. Raise side rails if ordered.
21. Make the client comfortable.
22. Place call device within reach.
23. Fasten tubing if unpinned before moving client.
24. Adjust bedding.
25. Wash your hands.

Steps of Procedure for Turning Client to Side

1. Wash your hands.
2. Identify and greet client.
3. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Raise bed to a comfortable working height.
7. Lock wheels on bed.
8. Lower backrest.
9. Lower side rail on side from which you are working.
10. If the client has any tubing that is pinned to the bedding, unfasten the tubing so that it will move freely with the client.
11. Remove pillow and loosen top sheets without exposing the client.
12. Check to see that the client has ample space to turn without falling off the edge of the bed. If not, have client move over more in bed, or move the client to the opposite side of the bed from which the client is being turned.
13. Cross the client's arms over his or her chest.
14. **Turning client toward you:**
    a. Cross the leg furthest from you over the leg closest to you.
    b. Reach across the client and put one hand behind far shoulder.
    c. Place your other hand behind far hip, gently roll the client toward you.

    Turning client away from you:
    a. Cross the leg closest to you over the leg furthest from you.
    b. Place one hand on the client's shoulder that is near you.
    c. Put your other hand under client's buttocks and turn gently onto side, facing away from you.
15. Fold a pillow lengthwise and place it against the client's back for support.
16. Support the client's head with the palm of one hand and slide a pillow under head and neck with the other hand.
17. Position client's knees slightly flexed, upper leg more flexed than the lower leg. Support upper leg by placing on a pillow.
18. Support upper arm by placing on a pillow.
19. For client with a nonfunctional side, place handroll or rolled washcloth in the client's hand and position thumb in opposition to fingers.
20. Lower bed to lowest position.
21. Raise side rails if ordered.
22. Make the client comfortable.
23. Place call device within reach.
24. Fasten tubing if unpinned before moving client.

25. Adjust bedding.
26. Wash your hands.

Turning Clients to a Prone Position

To help a client into the prone position, begin by placing the client on one side, but do not pull the lower arm and shoulder forward. The lower arm should stay down at the client's side. As the client turns, he or she must roll over the arm. A few clients are able to roll over with their arm extended over their heads, but this causes shoulder discomfort for many people. The client's top leg should be in front of, or crossed over, the lower leg.

Once the client is prone, the client's arms should be bent at the elbows and brought to rest next to the head. Be sure the client's toes are not in a cramped position. The client's feet may need to hang off the edge of the bed, or a pillow may be placed under the ankles for comfort.

The client's head must be turned to one side to allow free breathing. Be sure the prone position does not cause neck or back pain. If it does, the nurse assistant should return the client to a side-lying position and report the problem to the supervisor. Some clients prefer pillows at the head and chest.

The client's body should be aligned in a straight position. Some clients are more comfortable with a pillow under their abdomen while lying prone. To turn the client back to a supine (or flat-back) position, reverse the process; be sure the client has room to roll over safely.

The following procedure outlines the steps a nurse assistant would take when turning clients to a prone position.

Steps of Procedure for Turning Client to a Prone Position

1. Wash your hands.
2. Identify and greet client.
3. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Raise bed to a comfortable working height.
7. Lock wheels on bed.
8. Lower backrest.
9. Lower side rail on side from which you are working.
10. If the client has any tubing that is pinned to the bedding, unfasten the tubing so that it will move freely with the client.
11. Remove pillows and loosen top sheets without exposing the client.
12. Move the client to side of bed where you are.
13. Turn client to side.
14. Again, move the client to side of bed you are on, keeping the client on his or her side.
15. Position lower arm close to side.
16. Cross upper leg over lower leg.
17. Roll the client onto his or her abdomen.
18. Roll head to one side and place a small, firm pillow or folded blanket under the head. Do not use a full pillow as it may cause neck strain and interfere with breathing. CAUTION: Clients can smother if left unsupervised in prone position. A client should not be left in a prone position for an extended length of time, never more than 30 minutes, and many clients should not be left that long.
19. Position arms:
    a. Arm opposite the side to which head is turned may be left at side, other arm bent at elbow, and forearm positioned alongside head. OR
    b. Both arms remain at sides, slightly flexed at the elbows. OR

   c. Both arms bent at elbows and forearms positioned alongside head.

20. Place a small, firm pillow under the shoulder to which the head is turned.
21. For female clients, place a small, firm pillow under the abdomen to prevent pressure on breasts.
22. Extend feet over the end of mattress or slightly elevate feet off the mattress by flexing knees and placing a pillow under lower legs.
23. For client with a nonfunctional side, place handroll or rolled washcloth in client's hand and position the thumb in opposition to fingers.
24. Lower bed to lowest position.
25. Raise side rails if ordered.
26. Make the client comfortable.
27. Place call device within reach.
28. Fasten tubing if unpinned before moving the client.
29. Adjust bedding.
30. Wash your hands.

Using good body mechanics is even more critical in the home health setting. Many clients receiving care at home will not have beds with side rails or that are in any way adjustable. The home health aide should be sure to use the strong leg muscles rather than his or her back muscles to help position clients. Also, the nurse assistant should always get help from another caregiver when the client is too heavy for him or her to move alone.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 1: Moving and Positioning the Client

Activity Sheet

1. Why should the nurse assistant encourage clients to move and position themselves as much as possible?

    ____

    ____

2. What are two reasons the nurse assistant should get help in moving and positioning clients?

    a. ______________________________________

    b. ______________________________________

3. Where should the greatest support be given when moving a client?

    ____

4. What should be done to a piece of equipment or furniture to which you are moving the client before you begin the move?

    ____

5. What is good alignment?

    ____

    ____

6. What is a lift sheet? Where does it go? Why is it used?

    ____

    ____

7. Identify and describe an aid that can be added to the bed of a client who can help with moving and positioning.

    ____

    ____

8. List and describe the five positioning aids described in this lesson.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

   e. ______________________________

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedures, practice them in the laboratory setting with a partner:

   a. Assisting or raising a client's head and shoulders
   b. Moving a helpless client to the head of the bed
   c. Moving or assisting a client to the head of the bed
   d. Moving a client to one side of the bed
   e. Turning a client to his or her side
   f. Turning a client to a prone position

2. Examine a bed with a trapeze attached and practice using the trapeze as a grab bar to help yourself to get into and out of bed.

3. Examine bolsters, wedges, sandbags, and a footboard. Practice using them to position a partner.

Lesson 2:
Transferring the Client

Objectives:

A. Compare the types of client transfers.

B. Describe safety measures to observe when transferring clients.

C. Identify pieces of equipment used for transfer activities.

D. Discuss transferring clients at home.

E. Describe positioning and alignment of a client in a chair.

F. Transfer a client from bed to chair.

G. Transfer a client from chair to bed.

H. Transfer a client using the mechanical lift.

I. Transfer a client from bed to gurney.

J. Transfer a client using a three-person carry transfer.

K. Transfer a client using a two-person sitting transfer.

Key Terms:

- Transferring
- Independent transfer
- Dependent transfer
- Active-assisted transfer
- Passive-assisted transfer
- Orthostatic or postural hypotension
- Gait belt
- Sliding board
- Sling
- Mechanical lift

Transferring clients means moving them or helping them to move from one place to another. Many clients have lost some mobility and require assistance to be able to see their world from a place other than a bed.

Types of Transfers

An **independent transfer** is a transfer that a client can do without any direct assistance from another person. A **dependent transfer** is one that requires the assistance of at least one other person. Dependent transfers have two classifications: an active-assisted and a passive- assisted. An **active-assisted transfer** is one in which a client can provide some help. A **passive-assisted transfer** is one in which a client cannot help in any way and completely depends on others to do the work.

Safety Measures in Transferring Clients

The nurse assistant should determine before beginning any transfer whether the client can do the transfer or if he or she needs help. Clients who cannot bear any of their own body weight should not be transferred by one person.

Check all equipment for safety before beginning the transfer and make certain all necessary items are in place before approaching the client. The client should understand what is to be done and how he or she might help. The nurse assistant should use good body mechanics.

Transfers are much safer and easier if the two transfer surfaces are nearly the same height. For example, the bed should be lowered to a position that is the same height as the seat of the chair to which the client is being transferred. When transferring a client who has a weak or nonfunctional side, the nurse assistant should position the chair on the functional side. Weak clients often have difficulty maintaining their balance. When moving a weak client, the nurse assistant should have control of the client's shoulders and hips to be able to maneuver him or her in any direction.

All equipment should be locked during the transfer procedure. If seating a client in a standard room chair, it should be placed against a solid surface so it does not move out from under the client during the transfer. Beds that do not have locking wheels can be pushed up against a wall for stability. If using a wheelchair during the transfer, the footrests should be up and out of the way to prevent the nurse assistant or the client from tripping or stepping on them and falling.

A rapid change in position can cause the client's blood pressure to drop. The client may feel light-headed and dizzy when moving too quickly from a lying to a sitting position. This is called **orthostatic** or **postural hypotension**. To prevent a fall from occurring, change the client's position slowly or by degrees. For example, after raising the head of the bed, allow the client to remain in that position for several minutes. Before transferring a client to a chair, let the client's feet dangle over the side of the bed for a few minutes, as shown in Figure 2.1.

Equipment Used for Transfers

The **gait belt** is a special transfer belt made of heavy cotton cording that is placed around a client's waist. The belt provides a handle by which to lift, maneuver, and hold onto the client. Using a gait belt prevents arm injuries that could happen

Figure 2.1 - Allow Client to Rest Between Position Changes

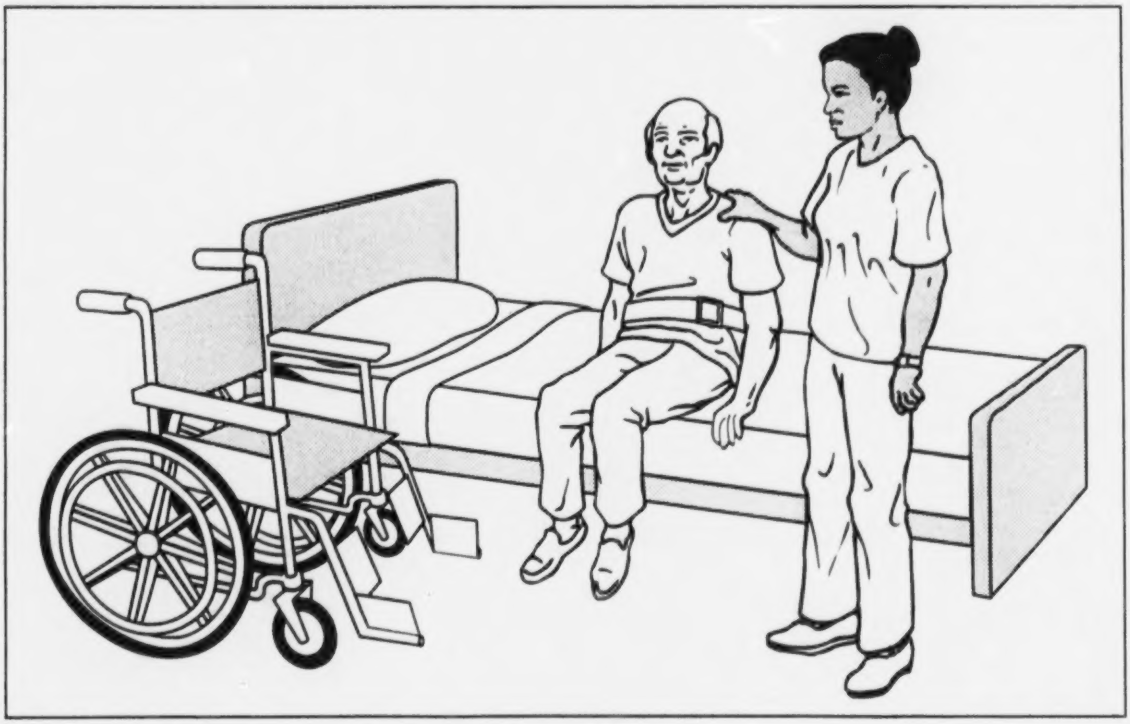


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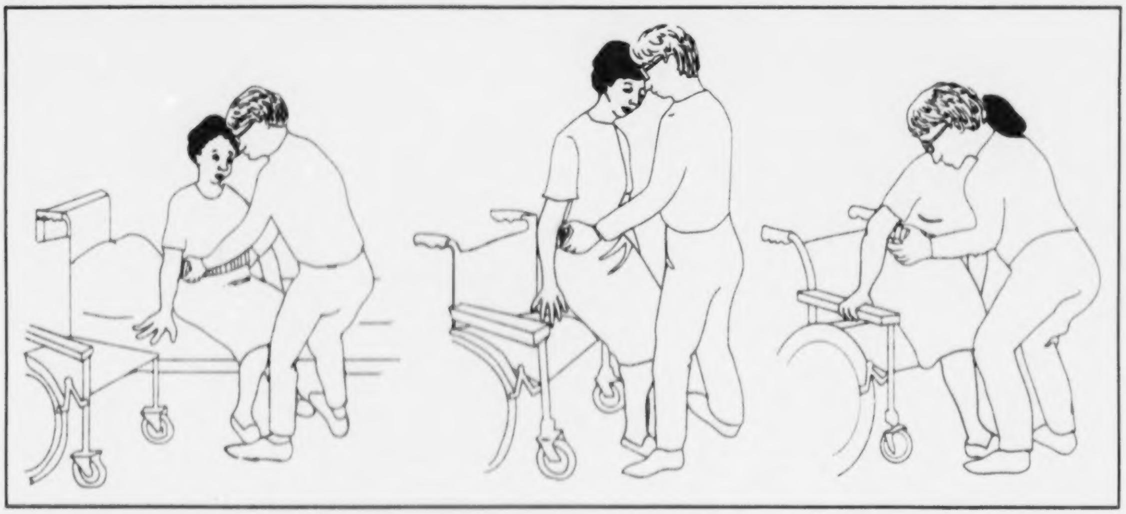
Figure 2.2 - Transferring a Client with a Gait Belt

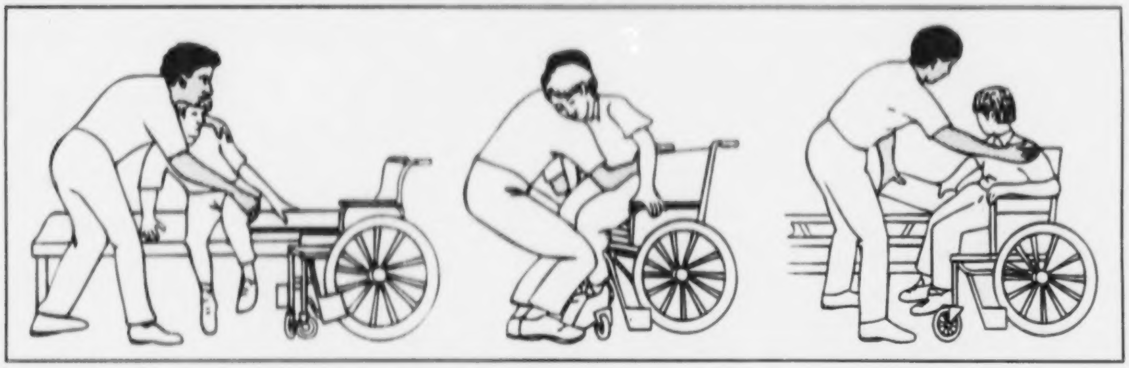


accidentally by pulling on a client's arms during a transfer. Apply the belt snugly, but not so tightly that it causes discomfort or impairs the client's ability to breathe. The nurse assistant should have enough room to slip a hand between the belt and the client's body. Figure 2.2 illustrates a nurse assistant transferring a client with a gait belt.

The **sliding board** is a smooth, varnished wooden or vinyl board about one foot wide and two feet long. One end is placed under the client and the other end is placed on the surface to which the client is transferring. The transfer surfaces must be about the same height. The client slides across the board as shown in Figure 2.3. To make the transfer easier, dust the board with talcum powder or cornstarch. Also, the client's clothes should also be suitable for sliding. The sliding board is used for clients who can maintain their balance in a sitting position but are too weak to stand up. Paralyzed clients who are unable to stand can also use the board to transfer from a bed to a wheelchair and back again.

The **sling** is a cloth device to cradle an injured or paralyzed arm or hand. The sling will help the client to maintain his or

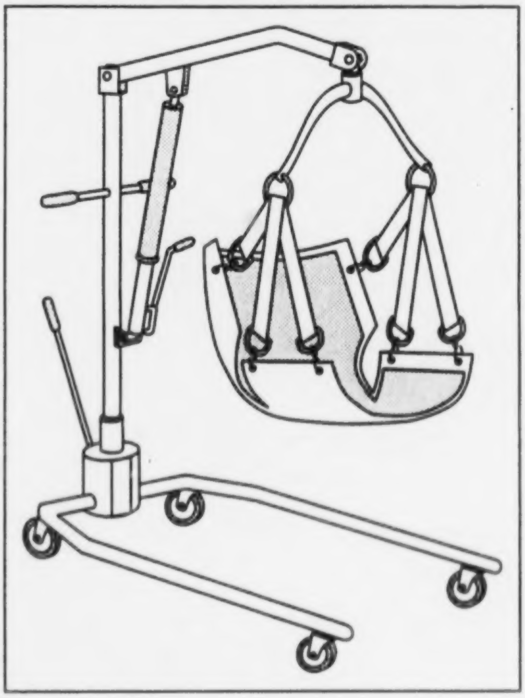
Figure 2.3 - Transferring a Client with a Sliding Board



her balance when transferring and ambulating. The sling also keeps the arm or hand confined close to the body so it is not injured during transfer.

A **mechanical lift** (see Figure 2.4) is used for transferring clients who are too heavy to lift. The client sits in a sling supported by an arm and frame. A crank or lever raises or lowers the arm and frame. For safety, two people should be present to manage the client and the device. Because the home health aide is frequently the only health care professional in the home, the aide may receive additional training in how to safely manage a mechanical lift transfer. Some mechanical lifts have adjustable bases that narrow for maneuvering and positioning under chairs and beds. Always place the base in its widest position before lifting the client.

Figure 2.4 - Mechanical Lift



Transfers in a Client's Home

Because the home health aide usually works alone, he or she must decide whether he or she can safely transfer the client. Other care providers may be in the house who know transfer techniques and can help. The home health aide should remember, however, that he or she remains primarily responsible for all care during the home health visit. Standard hospital equipment is not always available in the home, thus, the stability of beds and chairs should be checked and furniture positioned, as mentioned previously, to prevent falls. Chairs used to transfer clients should provide good support for the client's back. The chair should have arms and should not be so low that the client has difficulty getting up. If the home health aide must use a mechanical lift by him or herself, additional training is needed to manage the client safely.

A gait belt should be part of the equipment carried to the home by the home health aide. If a gait belt is not available, use a solid leather belt in its place.

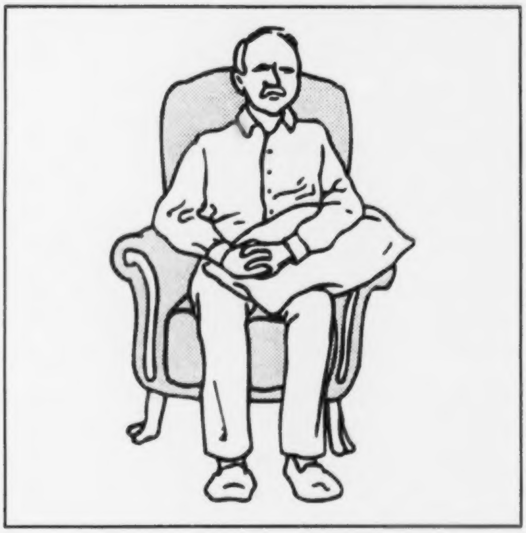
Positioning and Alignment of a Client in a Chair

Only a client who can control his or her head and neck should be placed in an upright position in a chair. If the client does not have this ability, angle the chair to recline in some way. Support the client's forearms with pillows to prevent strain on the shoulders. His or her back should be straight against the back of the chair. A small pillow can be placed in the lumbar curvature of the spine to increase the client's comfort. The hips and buttocks should be against the back of the chair. The backs of the knees should be free of pressure from the edge of the chair. The client is in the proper position if the nurse assistant can place two or three fingers between the back of the knees and the front of the chair. Do not allow the client's feet to dangle. Position feet flat on the footrests of a wheelchair or on the floor. The client should support his or her weight using the thighs and buttocks. The proper positioning for a client in a chair is shown in Figure 2.5.

To prevent prolonged pressure on the buttocks from sitting too long in a chair, the client must change position every two hours. If possible, the client should stand and walk. Clients who cannot move should be helped to shift from side to side. If they can move their upper body, they should lean to the right side of the chair and then to the left every thirty minutes.

Two people can reposition a client who slides forward in a chair. First, a gait belt is applied to the client's waist. Next, the two assistants stand on opposite sides of the client; each grasps the belt in back and places one hand under the client's thigh in front. Together the assistants lift and move the client back in the chair.

Figure 2.5 - Proper Positioning in a Chair



The following two procedures list the steps a nurse assistant would take when transferring a client from a bed to a chair and back again. These procedures can be accomplished with or without the help of the client.

Steps of Procedure for Transferring Client from Bed to Chair

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet the client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy.
7. Adjust bed height to low position.
8. Lock wheels on bed.
9. Raise head of bed to bring the client to a sitting position.
10. Help the client to move over in bed. He or she should be within five or six inches of the edge of the bed.
11. Help in putting on socks and nonskid shoes.
12. Position wheelchair on the client's strong side, if indicated, and brace the chair to prevent it from slipping.
13. Place the chair parallel to or at a 45° angle to the bed.
14. Lock the wheels of the chair.
15. Cover wheelchair with bath blanket and/or protective pad.
16. If possible, remove the armrest on the side next to the bed. Also, raise and remove footrests.
17. Position your body facing foot of bed.
18. Put one forearm under client's shoulders and other behind the knees.
19. Bend your knees, keep your back straight, and stand with feet shoulder width apart.
20. Straighten your hips and knees while shifting weight from your front foot to your back foot. At the same time, lift the client's head-neck with one arm while pulling the legs over the side of bed with other arm.

21. Apply gait belt.
22. Allow the client time for his or her circulation to adjust to being in a sitting position before you continue. Help the client in maintaining a sitting position as needed.
23. **If the client can help:**
    1. Place your hands underneath the belt along the client's side with palms up.
    2. Instruct the client to stand on the count of three.
    3. Assist the client to stand and support a weak leg with your knee, if indicated.
    4. Instruct the client to reach with his or her strong hand and grasp for the far armrest of the chair.
    5. Assist the client to pivot toward his or her strong leg by turning your own body. Do not twist; turn your body as a unit.
    6. Gently help the client to sit by bending your knees while keeping your back straight.
    7. Position the weak arm and leg properly on the armrest and footrest. Use a pillow to support the weak arm.

    If the client cannot help:
    - a. Stand directly in front of the client, grasp the back of the belt.
    - b. Support the client's knees and feet with your knees and feet, either knee-to-knee or your knees on the sides of the client's knees, whatever is comfortable for you and the client.
    - c. Have the client lean forward while sitting on the edge of the bed.
    - d. On the count of three, have the client push up as much as possible while you hold onto the belt and pull him or her up by straightening your legs and hips.
    - e. Pivot your entire body and the client's.
    - f. Lower the client into the chair by bending at your knees and hips as the client sits.
    - g. Adjust footrest for client; cover with a lap robe.
    - h. Position pillow(s) to provide proper body alignment and joint support.
24. Make the client comfortable.
25. Place call device within reach.
26. Wash your hands.

Steps of Procedure for Transferring Client from Chair to Bed

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet the client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy.
7. Adjust bed height to low position.
8. Lock wheels on bed.
9. Raise head of bed and fanfold bedclothes to end of bed. Make sure opposite side rail is raised.
10. Position chair/wheelchair at side of bed, facing head of bed.
11. Lock the wheels of the chair.
12. Bring up footrests, placing client's feet on the floor.
13. Remove lap robe/blanket.
14. Remove safety restraint, if applicable.
15. Apply gait belt.
16. Stand in front of the client. Your feet should be about shoulder width apart.
17. Place your hands underneath the belt. If the client is able, have him or her place hands on your shoulders.
18. Assist the client to stand and support a weak leg with your knee, as indicated.
19. Pivot your body and the client's body toward the bed.

20. Slowly lower the client to sitting position on the bed by bending your knees while keeping your back straight.
21. Remove gait belt.
22. Position your body facing the foot of the bed. One foot should be in front of the other foot.
23. Place one forearm on the client's shoulders and the other behind the client's knees.
24. Swing or assist the client's legs onto the bed as you pivot the client's body back into a supine or lying position.
25. Lower head of bed.
26. Help move the client to center of bed.
27. Remove slippers.
28. Cover client, position pillows, and straighten bed clothes.
29. Lower bed to lowest position.
30. Raise side rails if ordered.
31. Make the client comfortable.
32. Place call device within reach.
33. Wash your hands.

Transferring with a Mechanical Lift

A mechanical lift allows an experienced person to transfer a dependent client with relatively little effort. This equipment makes a transfer of a dependent client safe for both client and the nurse assistant if the equipment is used correctly. Different types of mechanical lifts are available, but their operations are similar.

The following procedure outlines the steps a nurse assistant would take in performing this task. The procedure is reversed to move the patient back to a bed.

Steps of Procedure for Transferring Client with Mechanical Lift

1. Ask another nurse assistant to work with you.
2. Wash your hands.
3. Assemble necessary equipment.
4. Identify and greet the client.
5. Identify self and other nurse assistant.
6. Explain what you are going to do.
7. Provide privacy.
8. Adjust bed height to low position.
9. Lock wheels on bed.
10. Position wheelchair next to bed. The back of the wheelchair should be in line with the headboard of the bed.
11. Position the sling under the client by turning the client from side to side on the bed. Place the top of the sling at the shoulders and the bottom above the bend of the knee.
12. Wheel the lift into place over the client. Put the lift's base beneath the bed.
13. Lock the wheels of the lift.
14. Lower the lift arm.
15. Attach the sling to the mechanical lift. The open, sharp ends of the hooks should face away from the client.
16. Have the client fold both arms across chest, if possible, or place in lap.
17. Using the crank, lift the client until the buttocks are clear of the bed. Make sure the client is aligned in the sling and is securely suspended in a sitting position with legs dangling over the bottom of the sling.
18. One caregiver should guide the client's legs over the edge of the bed while the other stabilizes the lift.
19. Unlock the wheels of the lift and, with one person stabilizing the sling, move the lift away from the bed.
20. The person stabilizing the sling guides the client toward the chair while the other person moves the lift toward the chair until the client is over the seat of the chair.
21. Release the control knob slowly so that the client will gradually be lowered into the chair.

22. Remove the hooks from the frame of the lift.
23. Cover the client with a lap robe.
24. Secure the client to the chair with safety restraint, if ordered.
25. Make the client comfortable.
26. Place call device within reach.
27. Store the lift properly until time to transfer the client again.
28. Wash your hands.

Transferring from Bed to Gurney

There are two ways to move a client from a bed to a gurney. Both methods require two or more caregivers to safely perform the transfer.

The first method involves sliding the client on a lift sheet from one surface to the other. The surfaces must be at almost the same height. The client should be lying on a regular bed sheet or blanket. The lift sheet is placed under the client's body and is used to transfer the client from one surface to another surface. Occasionally, a client will be transferred on a thin mattress instead of a lift sheet.

The second method requires the nurse assistant and helper to lift and carry the client, a necessity if the two surfaces are not the same height. In each instance, the client's body is kept straight, without bending at the neck, trunk, hips, or legs. If the client has lines or tubing, be careful not to pull on them.
The following procedure outlines the steps nurse assistants would take in performing this type of transfer.

Steps of Procedure for Transferring Client from Bed to Gurney

1. Ask two nurse assistants to work with you.
2. Wash your hands.
3. Assemble necessary equipment.
4. Identify and greet the client.
5. Identify self and other nurse assistants.
6. Explain what you are going to do.
7. Provide privacy.
8. Line up gurney so that it is parallel to the side of the bed.
9. Raise bed to height of gurney.
10. Lock or block wheels of all equipment
11. If the client has tubing that is pinned to the bedding, unfasten the tubing so that it will move freely with the client.
12. Loosen top covers of bed.
13. Remove all linen except top sheet.
14. Put the client in the supine position with arms folded over chest or positioned close to body.
15. Remove pillow.
16. Two nurse assistants stand beside gurney and reach across it to grasp the lift sheet under the client.
17. A third nurse assistant stands on the far side of the bed and grasps the lift sheet under the client.
18. On the count of three, the nurse assistants slide (lifting the client slightly and supporting the head) the client from the bed to the gurney. Be careful not to pull on lines or tubing.
19. Place pillow under the client's head.
20. Raise side rails on gurney.
21. Fasten tubing to gurney.
22. Cover the client with a sheet.
23. Unlock gurney wheels. The client is now ready for transport.
24. Adjust bed linens to open position in preparation for the client's return if appropriate.
25. Wash your hands.

NOTE: This procedure would probably not be used in the home health setting.

Three-Person Carry Transfer

If the surfaces between transfers are of unequal height, a lift and carry type of transfer is necessary. This is also the rescue lift used to evacuate clients in emergency situations. There may be other instances where this type of transfer is preferred. For an adult client, three caregivers are required. If the client has IV lines or other equipment attached, an additional person may be necessary.

The following procedure outlines the steps to be taken for this type of transfer.

Steps of Procedure for Transferring a Client Using a Three-Person Carry Transfer

1. Ask two nurse assistants to work with you.
2. Wash your hands.
3. Assemble necessary equipment.
4. Identify and greet the client.
5. Identify self and other nurse assistants.
6. Explain what you are going to do.
7. Provide privacy.
8. Position bed and gurney at right angles if possible.
9. Raise bed to height of gurney.
10. Lock or block wheels of all equipment.
11. If the client has tubing that is pinned to the bedding, unfasten the tubing so that it will move freely with the client.
12. Three nurse assistants line up along the side of the bed. The tallest person should be at the client's head and gives the commands.
    NOTE: A fourth person is needed if the client has IVs or other tubing and equipment.
13. The three nurse assistants slide their arms under the client.
14. On the count of three, they slide the client to the edge of the bed.
15. On the second command, the client is rolled toward the lifters' chests.
16. On the third command, they walk to the gurney and use good body mechanics by bending knees to lay the client down.
17. The nurse assistants carefully remove their arms from under the client.
18. Position the client comfortably.
19. Place pillow under the client's head.
20. Raise side rails on the gurney.
21. Cover the client with a sheet.
22. Fasten tubing to gurney.
23. Unlock gurney wheels. The client is now ready for transport.
24. Adjust bed linens to open position in preparation for the client's return if appropriate.
25. Wash your hands.

NOTE: This procedure would probably not be used in the home health setting.

Two-Person Sitting Transfer

If the client needs to be transferred between two surfaces of unequal height, the two-person sitting transfer can be used. If the client is particularly tall or heavy, or the caregivers are small, they may need additional help lifting the client's lower body.

The following procedure outlines the steps nurse assistants would take to perform this task.

Steps of Procedure for Transferring a Client Using a Two-Person Sitting Transfer

1. Ask another nurse assistant to work with you.
2. Wash your hands.
3. Assemble necessary equipment.
4. Identify and greet the client.

5. Identify self and other nurse assistant.
6. Explain what you are going to do.
7. Provide privacy.
8. Adjust bed height to low position.
9. Lock wheels on bed.
10. Position wheelchair where transfer is to take place, lock the wheels and raise footrests.
11. Raise head of bed to bring the client to a sitting position.
12. Position the taller and stronger lifter behind the client's head. This person stands and reaches under the client's arms and grasps the client's crossed wrists.
13. The other lifter stands in position by the side of the bed and reaches under the thighs and legs.
14. On the count of three, the client is lifted up and out of the bed and lowered into the wheelchair by bending at the knees and hips.
15. Adjust footrests for client; cover with a lap robe.
16. Position pillow(s) to provide proper body alignment and joint support.
17. Make the client comfortable.
18. Wash your hands.

NOTE: This procedure would probably not be used in the home health setting.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 2: Transferring the Client

Activity Sheet

1. List and define the four types of transfers.

   a. ____________________

   b. ____________________

   c. ____________________

   d. ____________________

2. List five safety measures to take in transferring clients.

   a. ____________________

   b. ____________________

   c. ____________________

   d. ____________________

   e. ____________________

3. Describe the following equipment and its use for transfers:

   a. gait belt ____________________

   ____

   b. sliding board ____________________

   ____

   c. sling ____________________

   ____

   d. mechanical lift ____________________

   ____

4. What is one factor the nurse assistant must consider when transferring a client in the home versus in a health care facility?

5. How should the client be positioned and aligned in a chair?

6. What is the procedure for repositioning a client who has slid forward in a chair?

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedures in the laboratory, practice them with a partner:

   a. transfer from bed to chair
   b. transfer from chair to bed
   c. transfer using a mechanical lift
   d. transfer from bed to gurney
   e. transfer using three-person carry transfer
   f. transfer using two-person sitting transfer

2. Examine a sliding board and a sling. Practice using this equipment with your partner.

3. Position your partner correctly in a chair.

4. Reposition your partner when he or she has slid forward in the chair.

Lesson 3: Ambulation

Objectives:

A. List the purposes of ambulation.

B. Describe the ambulation aids that can be used to assist a client.

C. Discuss general considerations when assisting a client with ambulation.

D. Identify safety measures that should be taken when assisting a client with ambulation.

E. Ambulate a client with a gait belt.

F. Ambulate a client who is using a walker.

G. Ambulate a client who is using a cane.

H. Ambulate a client who is using crutches.

Key Terms:

- Ambulation
- Assistive walking devices
- Three-point gait
- Four-point gait
- Brace

Ambulation means walking. Most adults do not remember learning to walk; it is an automatic exercise they do without conscious thought. Many clients have lost the ability to walk or are too weak to accomplish it on their own. Ambulating a client correctly is a skill every nurse assistant must develop to prevent complications of extended bed rest and to help clients to remain physically active.

Purposes of Ambulation

Ambulation promotes muscle tone, particularly in the leg and back muscle groups, which are used to support body weight and keep the body erect. Gradual, daily increases in ambulation will improve clients' strength and endurance. Without use, bones lose minerals and become very porous. Supporting body weight during walking helps to preserve the bone structure. Being able to ambulate gives the client greater independence and provides a sense of accomplishment. Ambulation stimulates the bowel to contract, causing peristalsis; an ambulatory client is less likely to have constipation. Ambulation also promotes blood circulation to clients' legs.

Ambulation Aids

Ambulation aids are sometimes called **assistive walking devices** which are items such as canes, crutches, and walkers that clients use for support when they ambulate. A physician or therapist prescribes the type of aid, depending on the client's weight-bearing status, balance, strength, and experience with ambulation aids. The ordered device is specially fitted to the client; only the client should use the device.

Clients who require some support when walking due to problems with balance or due to weakness may use a walker. The walker can also be used when the client has good upper body strength but can only bear weight on one leg, such as after hip or knee surgery. Walkers may or may not have wheels. Two types of walkers are shown in Figure 3.1. A walker without wheels is used when the client has enough strength to lift the walker up and move it forward. The client should not slide a walker without wheels along the floor or ground. A walker with wheels is ordered for a client who has poor upper body strength and difficulty directing the device, but can support his or her body weight using their legs. The height of the walker is adjusted so that the client is standing straight with the elbows slightly flexed when gripping the hand rests of the walker. Some walkers fold to save space when stored. Clients who use walkers rarely use them on stairs. Clients who must use stairs may use a special stair-walker. An alternative is for the client to hold the walker frame with one hand, angle the walker on the stairs, and use the stair handrail to provide stability. Clients also need to learn how to step up onto and down from a curb with a walker. The walker must be placed completely up or down on the level that the client is stepping to. The client should not set the walker with two of the legs on each level; the walker is likely to tip. The client can step up onto the curb backward, then lift the walker and swing it around to the front.

A client who can bear his or her full weight may use a cane to help maintain balance. Canes are made of wood or metal. Metal canes are usually adjustable to the client's height. A quad cane has four legs that provide a wider base, giving more stability than a single-tip cane. The cane should be held in the hand opposite the weak or painful lower extremity. The height of the cane should be adjusted so that the client's elbow is slightly bent when walking. The client should place the tip or base of the cane 6-10 inches from the side of the foot, keeping the handle level with the hip. When the client walks, the cane and the stronger, lower extremity are moved first, then the weaker, lower extremity. Figure 3.2 shows different types of canes.

Clients who have sufficient upper-body strength to support their body weight can use crutches. Crutches may be used as an ambulation aid by clients with various abilities to bear weight on the lower

Figure 3.1 - Types of Walkers

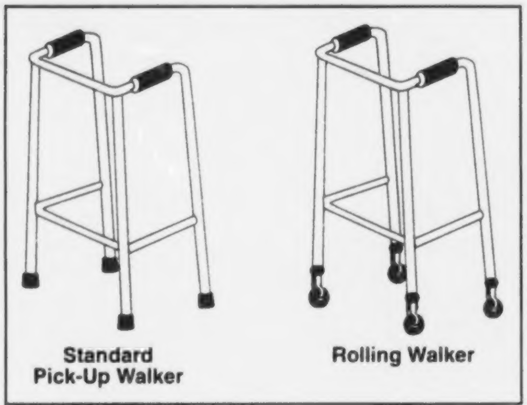


Figure 3.2 - Types of Canes

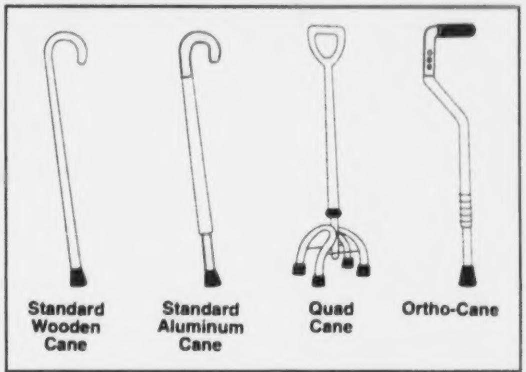
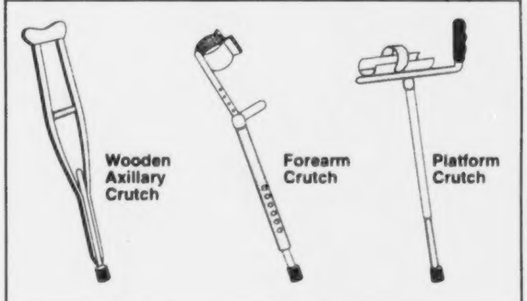


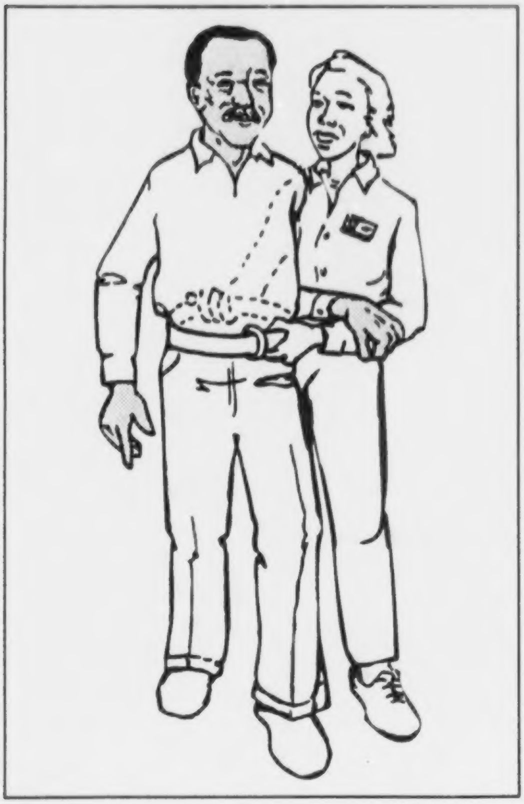
Figure 3.3 - Types of Crutches



extremities. Crutches are available in wood or metal and are adjustable in height. Axillary crutches fit under the arm as the client bears his or her weight on the hands. Forearm crutches fit around the client's forearm. The client still bears weight on the hands, but the forearm crutch keeps the client's body weight off the axillary or armpit area. Crutches may also be modified with a forearm platform for clients who must bear weight on the elbows instead of their hands or wrists. Figure 3.3 shows different types of crutches.

The client may use different gait patterns with crutches depending on how much weight he or she can bear on the lower extremities. The physician or therapist determines which gait pattern the client will use. A **three-point gait** can be used if a client is nonweightbearing or partial weightbearing. The three points are the two crutches and the unaffected foot. The two crutches are moved forward, then the client swings the unaffected leg up to or beyond the crutches. If the client can bear partial or full weight on an affected extremity, the four-point gait is used. In the **four-point gait**, the client moves the crutch on the affected side and then the opposite lower extremity. The client then moves the crutch on the unaffected side and brings the affected extremity forward. All four "points" are moved separately. When a client is secure with this gait, he or she may progress to moving a crutch and the opposite lower extremity forward at the same time, alternating sides.

Figure 3.4 - Using a Gait Belt



A **brace** is used for the client who needs specific support for weakened muscles or joints or immobilization of an injured part. Braces can be made of formed plastic with Velcro™ fastenings or be made of leather and metal supports. Never loosen a brace's screws and bolts because it is specially fitted to the person. When applying or removing a brace, always check the client's skin under the brace for signs of irritation, rubbing, or breakdown. When not in use, braces should be propped in a normal wearing position to retain their shape.

The transfer or gait belt is discussed in Unit VI, Lesson 2. It is a device used by the nurse assistant to guide and support the client during ambulation and other activities. The belt is grasped with both hands when helping to lift, transfer, and guide the client. To help the client ambulate, the nurse assistant should put one hand under the gait belt at the client's waist in back and the other hand on top of the gait belt at the client's waist in front. The procedure is illustrated in Figure 3.4. The nurse assistant should walk on the client's weakest side and encourage the client to use his or her strong arm for support on handrails and against walls.

General Considerations in Assisting with Ambulation

The nurse assistant should observe clients carefully to determine if they have sufficient strength to ambulate. Nurse assistants should never let clients ambulate independently if they have doubts about the client's ability to do so. Many clients will need assistance with ambulation for various reasons. Figure 3.5 identifies reasons why clients may need assistance with ambulation.

Clients should wear appropriate clothing to protect their modesty when ambulating. The nurse assistant should observe a client's ambulation for steadiness of gait, balance, and endurance. Closely watch the client during ambulation for signs of fatigue, such as difficulty breathing, sweating, dizziness, and rapid heart beat. If any of these signs are present, the client should rest before continuing with ambulation. If the signs do not improve with rest, the client should return to bed and the supervisor should be notified. Report any changes in a client's ability in ambulation to the supervisor.

Safety Measures when Assisting with Ambulation

Nurse assistants should use good body mechanics to protect themselves and clients from injury. If a client has been lying down, he or she should sit briefly at the side of the bed before ambulation. Ambulation should occur in an area that is free from clutter with all objects and other clients out of the way. The ambulation area should have handrails along the walls, and the floors should not be slippery. The client should wear nonskid shoes or slippers. If ambulation occurs in the home, a stable surface such as the wall should be available for the client to balance against. The nurse assistant should always be prepared to help the client to sit. A chair should be nearby or ready at the end of the planned ambulation distance so that the client may rest.

The nurse assistant should know how to use assistive devices properly. Using improper techniques can be hazardous rather than helpful. The rubber tips on canes, crutches, and walkers should be checked frequently to insure that they are not worn through to the metal or wood. Before the client attempts to use an assistive device, make sure that the screws and bolts are securely in place. Canes and walkers are not stable enough for the client to use to pull up to a standing position. If clients show signs of fatigue, encourage them to rest to prevent complete exhaustion and falls.

If a client starts to fall and cannot be stabilized with the gait belt, the nurse assistant should pull the client close with the gait belt. The client should then slide down along the nurse assistant's hip and thigh to the floor.

Figure 3.5 - Reasons Why Clients May Need Assistance with Ambulation

- Decreased muscle strength
- Changes in the center of gravity and inability to maintain upright body posture
- Decreased sensory perception
- Impaired balance
- Confusion
- Drugs that cause clients to be weak or to lose their balance
- Being easily distracted and prone to falls
- Previous falls

Steps of Procedure for Ambulating Client with a Gait Belt

1. Wash your hands.
2. Identify and greet the client.
3. Identify self.
4. Explain what you are going to do.
5. Make sure client has on appropriate attire for ambulation.
6. Lower bed to lowest level.
7. Assist the client to sit on edge of bed.
8. Pause and allow the client to sit a few moments to regain balance.
9. Assist the client in putting on nonskid shoes and socks.
10. Put a gait belt around the client's waist.
11. Stand in position of good body mechanics.
12. Help the client to a standing position by grasping belt at the client's sides.
13. Straighten your legs as you lift with the gait belt and the client pushes down with hands on the mattress.
14. Pause to allow the client to regain balance by placing his or her hands on your forearms.
15. Place one arm in front of the client's waist and the other hand in back under the gait belt. Walk with the client. Walk on the weakest side and encourage the client to use his or her strong arm to hold handrail, if available.
16. Walk in the same pattern as the client (both step with left feet at the same time). Help the client to step forward with strong foot first.
17. Walk the client the distance instructed by supervisor.
18. Return the client to bed/chair.
19. Make sure client is comfortable.
20. Place call signal within reach.
21. Remove gait belt.
22. Wash your hands.
23. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Ambulating Client Using a Walker

1. Wash your hands.
2. Identify and greet the client.
3. Identify self.
4. Explain what you are going to do.
5. Make sure client has on appropriate attire for ambulation.
6. Lower bed to lowest level.
7. Assist the client to sit on the edge of bed.
8. Pause and allow the client to sit a few moments to regain balance.
9. Help the client put on nonskid shoes and socks.
10. Apply a gait belt.
11. Stand in position of good body mechanics.
12. Assist the client to a standing position.
13. Instruct the client to position body within the frame of the walker.
14. Instruct the client to move the walker forward by lifting it up.
15. Instruct the client to take a step forward with the weak leg while supporting self with walker and stronger leg.
16. Instruct the client to move strong leg forward.
17. Walk the client the distance instructed by supervisor.
18. Return the client to bed/chair. To ambulate backward, the client steps backward with his or her strong foot, takes a step back with the weak foot, then moves the walker back. Have the client feel with his or her hand for the chair arm or the mattress.
19. Remove gait belt.
20. Make sure client is comfortable.
21. Place call signal within reach.
22. Wash your hands.
23. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Ambulating Client Using a Cane

1. Wash your hands.
2. Identify and greet the client.
3. Identify self.
4. Explain what you are going to do.
5. Make sure client has on appropriate attire for ambulation.
6. Lower bed to lowest level.
7. Assist the client to sit on edge of bed.
8. Pause and alow the client to sit a few moments to regain balance.
9. Help the client put on nonskid shoes and socks.
10. Apply a gait belt.
11. Stand in position of good body mechanics.
12. Assist the client to a standing position.
13. Instruct the client to take short steps and keep head up and eyes looking forward.
14. Instruct the client to move cane forward and a little out to the side of the strong leg.
15. Instruct the client to move weak extremity forward to line up evenly with the tip of cane just after cane is placed.
16. Instruct the client to put weight on cane and his or her weak foot while swinging the strong foot forward, taking a step.
17. Walk in the same pattern as the client (both step with the left foot at the same time).
18. Walk the client the distance instructed by supervisor.
19. Return the client to bed/chair.
20. Remove gait belt.
21. Make sure client is comfortable.
22. Place call signal within reach.
23. Wash your hands.
24. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Ambulating Client With Three-point, Nonweightbearing Gait Using Crutches and Contact Assistance

1. Wash hands.
2. Identify and greet client.
3. Identify self.
4. Explain what you are going to do.
5. Make sure client has on appropriate attire for ambulation.
6. Lower bed to lowest level.
7. Assist the client to sit on edge of bed.
8. Pause and allow the client to sit a few moments to regain balance.
9. Help the client put on nonskid shoes and socks as appropriate.
10. Apply gait belt.
11. Stand on the side of the client's affected leg. Position crutches to front and side of bed on affected side, and have client hold crutches at handholds. NOTE: Use good body mechanics throughout procedure.
12. Ask client if he or she is ready to stand up; grasp gait belt in back with one hand, and place opposite hand lightly at client's shoulder.
13. Ask client to stand up without putting weight on affected foot. Give client a moment to regain balance.
14. Observe as client uses free hand to grasp the hand hold of a crutch and place it under arm on unaffected side.
15. Observe as client rotates other crutch around and under arm on affected side.
16. Allow client time to adjust clothing and crutches for comfort and to be sure crutches are securely under arms.
17. Ask client if he or she is ready to ambulate. Have client hold affected leg off floor and move crutches forward, steadying at gait belt and shoulder if necessary.
18. Remain in contact with the client as he or she presses down with hands

and swings unaffected foot forward, keeping affected foot off floor.

19. Continue ambulating to the specified distance.
20. Return client to chair, allowing client to back up to the chair until the back of the unaffected leg touches it.
21. Remain in contact while client takes crutch out from under arm on affected side and holds it by the handpiece.
22. Observe as client takes crutch out from under unaffected side and moves it to the hand on the affected side so that the two crutches are lined up.
23. Observe and assist as necessary as client reaches back to grasp arm of chair on unaffected side and sits down.
24. Move crutches out of the way.
25. Remove gait belt.
26. Make sure client is comfortable.
27. Place call signal within reach.
28. Wash hands.
29. Record pertinent observations and report unusual occurrences to supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 3: Ambulation

Activity Sheet

1. List three purposes of ambulation.

   a. ____

   b. ____

   c. ____

2. Describe the following ambulation aids:

   a. walker ____________________________________

   b. cane ____________________________________

   c. quad cane ____________________________________

   d. crutches ____________________________________

   e. brace ____________________________________

   f. transfer or gait belt ____________________________________

3. List six reasons why a client may need assistance with ambulation.

   a.____________________ d.____________________

   b.____________________ e.____________________

   c.____________________ f.____________________

4. What are three observations the nurse assistant should make while the client is ambulating?

   a.____________________________

   b.____________________________

   c.____________________________

5. List ten safety measures to take when assisting a client with ambulation.

   a. ____

   b. ____

   c. ____

   d. ____

   e. ____

   f. ____

   g. ____

   h. ____

   i. ____

   j. ____

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedures, practice them in the laboratory with a partner.

   a. Ambulate a client with a gait belt
   b. Ambulate a client with a walker
   c. Ambulate a client with a cane
   d. Ambulate a client who is using crutches

2. Practice guiding a partner to the floor when they fall during ambulation.

Lesson 4:
Range of Motion Exercises

Objectives:

A. Identify the purposes of range of motion exercises.

B. Compare the types of range of motion exercises.

C. Discuss the general considerations in performing range of motion exercises.

D. Perform range of motion exercises.

E. Assist with active range of motion exercises.

Key Terms:

- Range of motion (ROM) exercises
- Atrophy
- Contracture
- Passive ROM exercises
- Active-assistive ROM exercises
- Active ROM exercises
- Resistive ROM exercises

The human body is like a machine with many moving parts. If a machine is not used or if it is not kept well oiled, the parts stiffen and may refuse to work. The same thing happens with human bodies. Bodies must keep moving to remain functional. Body parts must move for us to be able to accomplish most activities of daily living. **Range of motion (ROM) exercises** move the joints of the body through their normal pattern of movement.

Purposes of Range of Motion Exercises

Muscles must be exercised to remain healthy. Range of motion exercises will prevent **atrophy**, the shrinking and loss of muscle strength. To prevent the joints from becoming stiff, range of motion exercises are done to promote flexibility. A deformity of a joint caused when strong muscle groups in a body part contract or draw into a fixed position, called a **contracture**, will occur if a joint is not exercised. Range of motion exercises, like ambulation, prevents the loss of minerals from the bones. Any type of exercise will promote circulation, including range of motion exercises that must be done for the client.

Types of Range of Motion Exercises

There are four types of range of motion exercises. The nurse assistant does **passive ROM exercises** on a client who does not help in any way. In **active-assistive ROM exercises**, the client moves as independently as possible. The nurse assistant does range of motion for joints that the client cannot move or has difficulty moving. The client does **active ROM exercises** without assistance. The client may require supervision or encouragement to complete active ROM activities. When **resistive ROM exercises** are done, the client moves the joint through its range of motion as the nurse assistant provides pressure resistance. Muscle strength is increases because the client must work a little harder to do these exercises.

General Considerations in Performing Range of Motion Exercises

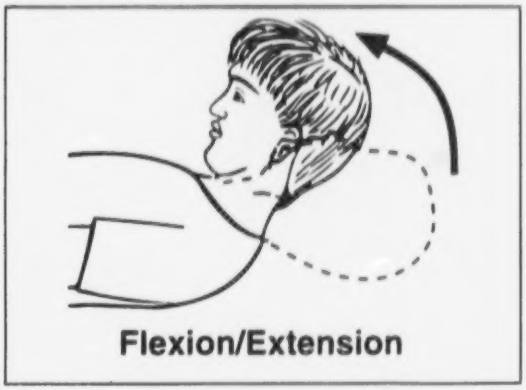
Types of joint movement are discussed in the skeletal system lesson of the *Health Care Assistant Core* curriculum. Review the movements before beginning the procedure for performing ROM exercises.

The nurse assistant should know any limitations or restrictions in doing range of motion exercises before starting the procedure. The supervisor can give directions regarding a client's capabilities. Home health aides who are working under the direction of physical or occupational therapists should have detailed explanations from the therapists regarding their responsibilities.

ROM exercises may be done any time during the day. If the exercises are done during or after a bath, the muscles may be more flexible due to the relaxing effect of warm water. For clients with arthritis, joint movement is easier after they have been up and moving. ROM exercises may be best scheduled after pain medication or medications that decrease inflammation have been administered to a client.

Joints are never exercised to the point of pain. A physician or therapist may order the number of repetitions for the joint movement. If the number of repetitions is not specified, the standard is usually three to five times depending on the number of repetitions needed to exercise the joint adequately. If discomfort or pain develops, stop the exercises and report the occurrence to the supervisor.

Figure 4.1 - Neck



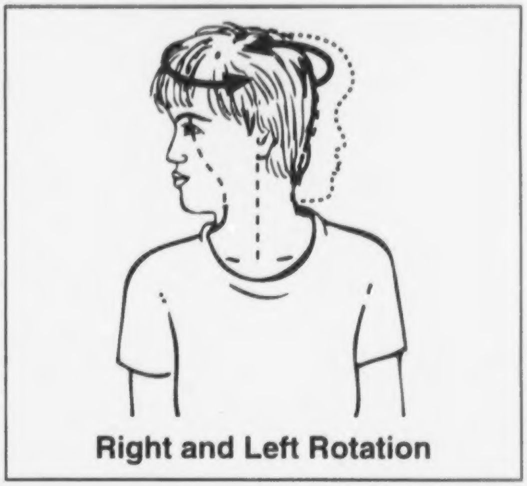
Flexion/Extension

The motions should be slow and smooth. The body part above and below the joint being exercised should be supported. The grip on the body part should be light but firm and fingertips should not dig into the muscle. The client should be encouraged to help with the exercises as much as possible. If the client is in a supine position while the exercises are being done, hyperextension will not be possible. Clients who are able to do active ROM exercises can do steps 8-13 of the following procedure by themselves.

Steps of Procedure for Performing Range of Motion Exercises

1. Wash your hands.
2. Identify and greet the client.
3. Identify self.
4. Explain what you are going to do.
5. Provide privacy. The client should wear adequate clothing.

Figure 4.2 - Neck



Right and Left Rotation

Figure 4.3 - Shoulders

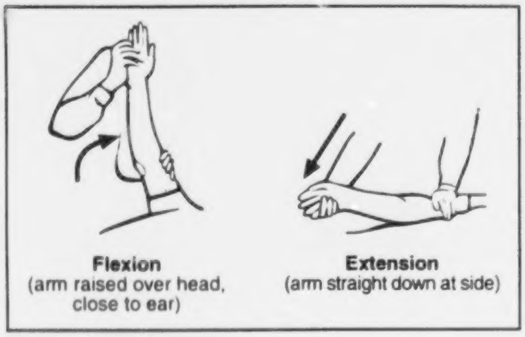

Flexion
(arm raised over head, close to ear)
Extension
(arm straight down at side)

Figure 4.4 - Shoulders

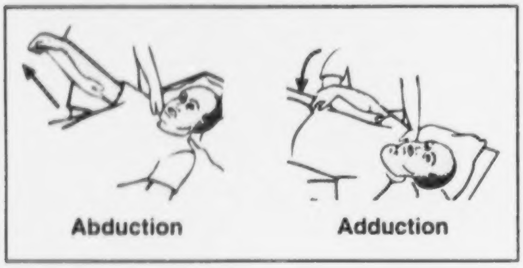

Abduction
Adduction

Figure 4.5 - Shoulders

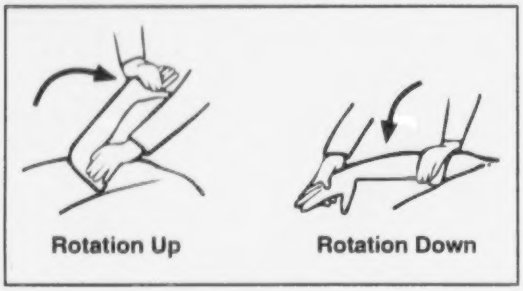
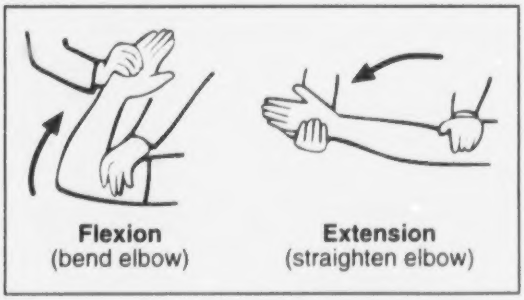
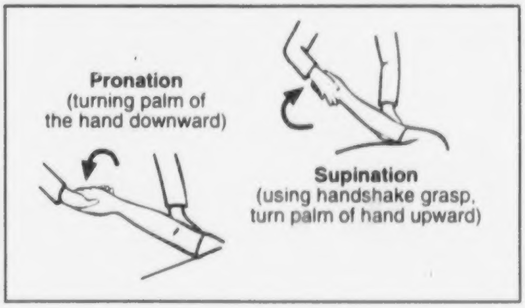

Rotation Up
Rotation Down

Figure 4.6 - Elbows


Flexion
(bend elbow)
Extension
(straighten elbow)

6. Raise bed to a comfortable working height.
7. Assist the client into supine position.
8. Neck
   a. Flexion/Extension (see Figure 4.1)
      (1) Support head with hands and bend head forward, trying to touch the chest with the chin.
      (2) Bring head back to pillow.
   b. Right and left rotation - turn head from side to side (see Figure 4.2)
9. Shoulders
   a. Flexion/Extension (Figure 4.3)
      (1) Support the arm at the wrist and elbow and lift the arm toward the ceiling. Continue lifting the arm over the client's head until you feel resistance.
      (2) Slowly lower the arm to the client's side.
   b. Abduction/Adduction (Figure 4.4)
      (1) Support the arm at the elbow and shoulder and move the arm out to the side, continue moving toward the client's head.
      (2) Slowly move the arm back toward the center of body.
   c. Lateral/Medial Rotation (Figure 4.5)
      (1) Move the arm away from the body to shoulder level.
      (2) Bend the elbow at a 90° angle. Rotate the hand forward to touch the bed and then backward to touch the bed.

Figure 4.7 - Elbows


Pronation
(turning palm of the hand downward)
Supination
(using handshake grasp, turn palm of hand upward)

10. Elbows
    a. Flexion/Extension (see Figure 4.6)
        (1) Bend the arm at the elbow and touch the shoulder, then straighten the arm.
        (2) Bend the arm at the elbow and touch the chin, then straighten the arm.
        (3) Supination/Pronation (see Figure 4.7)
        (4) Hold the client's hand in a handshake position; support the arm at the elbow joint with the elbow slightly bent.
        (5) Turn palm of the hand up then downward.

Figure 4.8 - Wrists

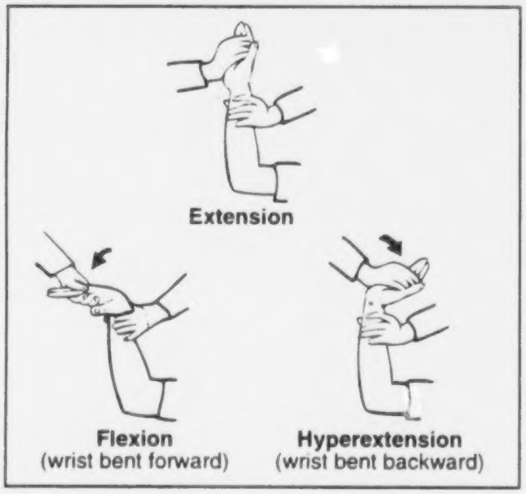
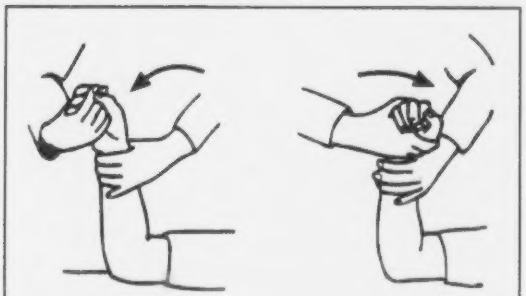

Extension
Flexion
(wrist bent forward)
Hyperextension
(wrist bent backward)

Figure 4.9 - Wrists


Abduction
Adduction

11. Wrists
    a. Flexion/Extension/Hyperextension - support arm and hand; bend the wrist forward, straighten it, and then bend it backward. (Figure 4.8)
    b. Abduction/Adduction - move the hand from side to side at the wrist. (Figure 4.9)

Figure 4.10 - Fingers

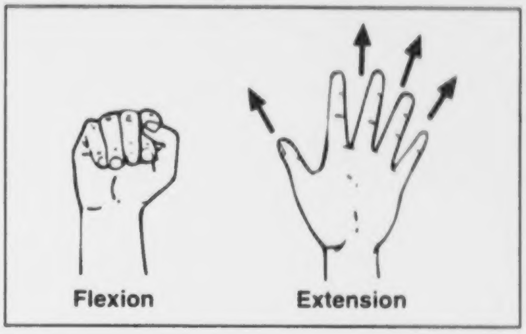

Flexion
Extension

Figure 4.11 - Fingers

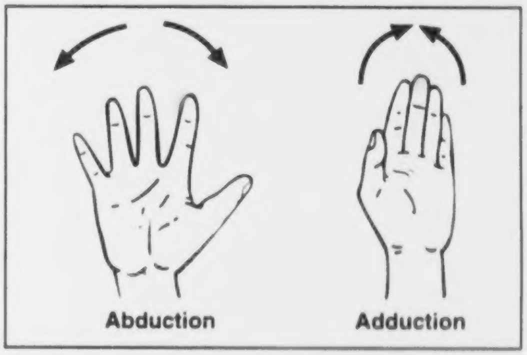

Abduction
Adduction

Figure 4.12 - Fingers

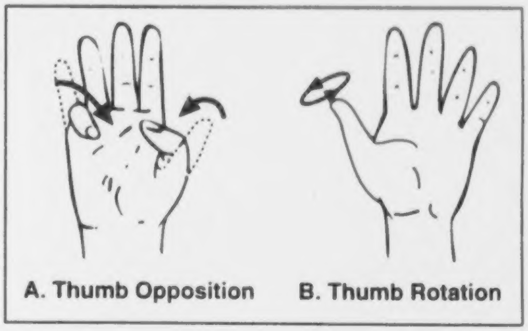

A. Thumb Opposition
B. Thumb Rotation

Figure 4.13 - Hips and Knees

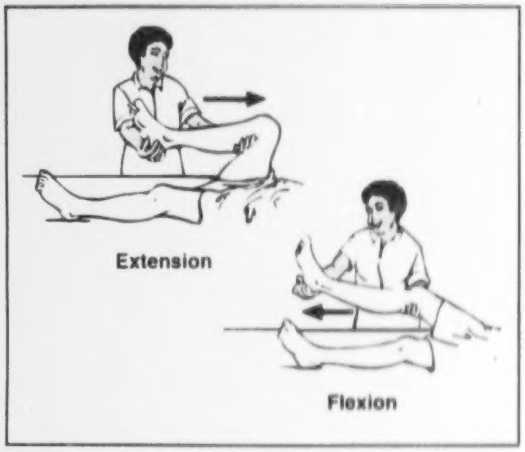


Figure 4.14 - Hips and Knees

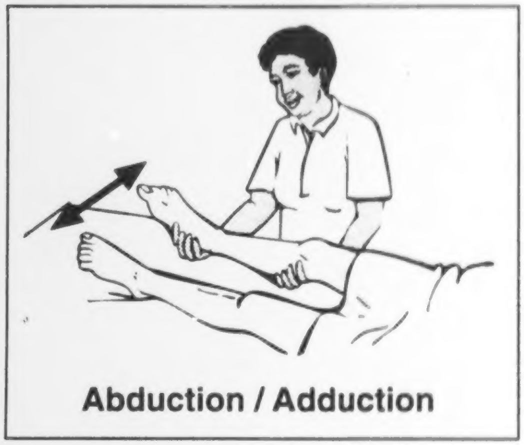
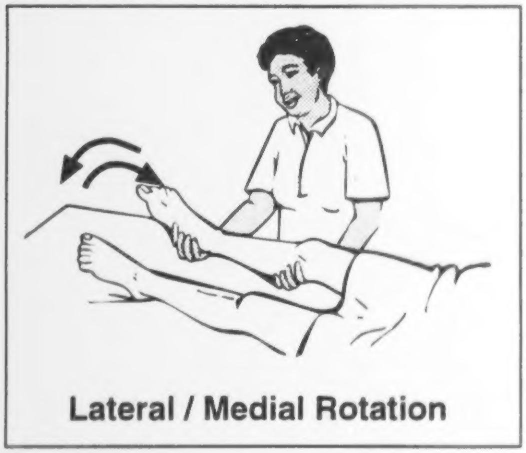


Figure 4.15 - Hips and Knees

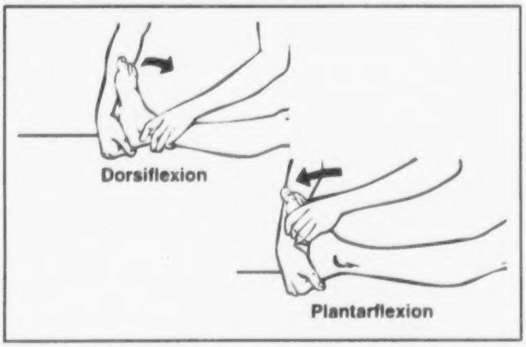


12. Fingers
    a. Flexion/Extension - support the hand at the wrist; make sure that the thumb is on top of the fingers. Instruct the client to make a clenched fist and then relax it. (see Figure 4.10)
    b. Abduction/Adduction - move each finger away from the nearest finger and then return it. (see Figure 4.11)
    c. Thumb Opposition - bend the little finger toward inner hand and stretch the thumb toward the little finger and move it to the base of the little finger and back. (see Figure 4.12A)
    d. Thumb Rotation - move the thumb in a circle one direction and then the other direction. (see Figure 4.12B)
13. Hips and Knees
    a. Flexion/Extension (Figure 4.13)
        (1) Support the leg at the knee and ankle joints, keep the knee straight; raise and lower the leg.
        (2) Bend the knee and move toward the chest, slowly straighten the knee.
    b. Abduction/Adduction (Figure 4.14)
        (1) Move the leg straight out to the side of the body until you feel resistance.
        (2) Slowly move the leg back toward the center of the body.
    c. Lateral/Medial Rotation - support the knee and ankle joints; roll the leg in toward the opposite leg and then outward (Figure 4.15).

14. Ankles and Feet
    a. Inversion/Eversion - support the foot at the ankle joint and turn the sole of the foot toward the opposite foot and then away from the opposite foot (Figure 4.16).
    b. Dorsiflexion/Plantarflexion - bend the foot up toward the knee, then down toward the floor (Figure 4.17).
15. Toes
    a. Flexion/Extension - bend and then straighten the toes (Figure 4.18).
    b. Abduction/Adduction - move each toe toward the next toe and then away from the next toe. (Figure 4.19)
16. Lower bed to lowest position
17. Raise side rails if ordered.
18. Make the client comfortable
19. Place call signal within reach.
20. Wash your hands.
21. Record pertinent observation and report unusual occurrence to supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Figure 4.16 - Ankles and Feet



After you have completed the activity sheets, you may take the written evaluation for this unit. A score of at least 80 percent indicates you may proceed to the next unit. Check with your clinical supervising staff member for skill testing.

Figure 4.17 - Ankles and Feet

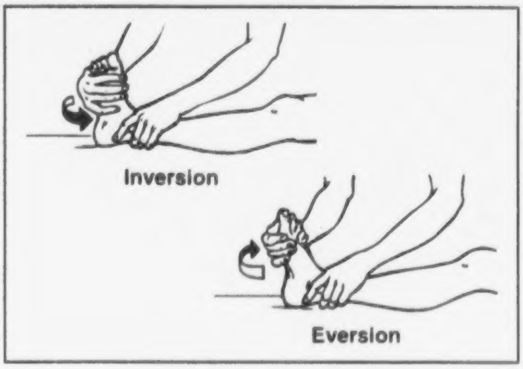


Figure 4.18 - Toes

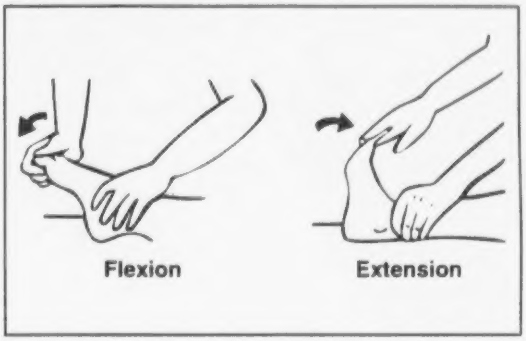
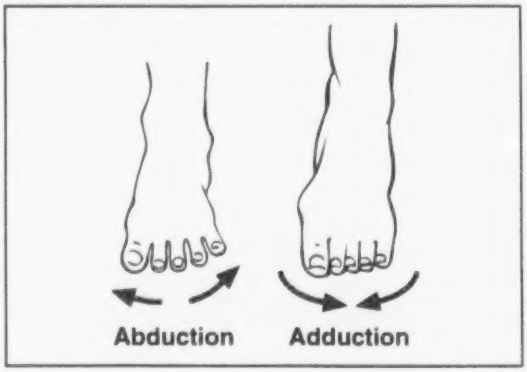


Figure 4.19 - Toes



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Lesson 4: Range of Motion Exercises

Activity Sheet

1. List three purposes for doing range of motion exercises.

____

____

____

2. List and compare the four types of range of motion exercises.

   a. ______________________________

   ____

   b. ______________________________

   ____

   c. ______________________________

   ____

   d. ______________________________

   ____

3. At what time might it be easier for the client to help with range of motion exercises?

____

____

4. How many times should the exercise to each joint be done?

____

____

5. How should the body part to be exercised be held?

____

Restorative Nursing, page 6.43

6. What is the nurse assistant's role in active ROM exercises?

____

____

Clinical/Laboratory Activities

1. After a physical therapist or the instructor has demonstrated the procedure, practice doing range of motion exercises with a partner. Try both passive and resistive ROM exercises.

Unit Checklist

Student Name ______________________________ Overall Unit Rating ________

Activity Sheet: Moving and Positioning the Client Rating ________

Comments: ____

____

____

Skill Sheet: Assist with or Raise a Client's Head and Shoulders Rating ________

Skill Sheet: Move Helpless Client to the Head of the Bed Rating ________

Skill Sheet: Move or Assist Client to the Head of the Bed Rating ________

Skill Sheet: Move Client to One Side of the Bed Rating ________

Skill Sheet: Turn Client to Side Rating ________

Skill Sheet: Turn Client to Prone Position Rating ________

Activity Sheet: Transferring the Client Rating ________

Comments: ____

____

____

Skill Sheet: Transfer Client from Bed to Chair Rating ________

Skill Sheet: Transfer Client from Chair to Bed Rating ________

Skill Sheet: Transfer Client with Mechanical Lift Rating ________

Skill Sheet: Transfer Client from Bed to Gurney Rating ________

Skill Sheet: Transfer Client Using a Three-Person Carry Transfer Rating ________

Skill Sheet: Transfer Client Using a Two-Person Sitting Transfer Rating ________

Activity Sheet: Ambulation Rating ________

Comments: ____

____

____

Skill Sheet: Ambulate Client With a Gait Belt Rating ________

Skill Sheet: Ambulate Client Using a Walker Rating ________

Skill Sheet: Ambulate Client Using a Cane Rating ________

Skill Sheet: Ambulate Client With Three-Point, Nonweightbearing Gait Using Crutches and Contact Assistance Rating ________

Activity Sheet: Range of Motion Exercises Rating ________

Comments: ____

____

____

Skill Sheet: Perform Range of Motion Exercises Rating ________

Written Unit Evaluation Score ________

Additional Comments: ____

____

____

Teacher Signature ______________________________ Date ____________

Student Signature ______________________________ Date ____________

Unit VII

Nutrition

Food is an extremely important part of life. It provides the body with the fuel required to complete its work and maintain health. People also use it as a source of comfort and opportunity for socialization. When the body is weak and is attempting to recover from an illness, food is necessary to provide the nutrients by which the body repairs itself. Many clients can no longer feed themselves because they are too weak or too ill. If they are to recover, serving and feeding clients and monitoring their nutritional status is an important aspect of care.

Unit Lessons

Preparing the Client for Meals: Serving, Feeding and Monitoring

Intake and Output

Weight and Height

Lesson 1:
Preparing the Client for Meals: Serving, Feeding and Monitoring

Objectives:

A. Discuss general considerations in preparing clients for mealtime.

B. Prepare a client for a meal.

C. Explain how to prepare and serve food trays.

D. Distribute trays, assisting with tray set-up.

E. Identify key points in feeding a client.

F. Feed a helpless client.

G. Describe after-meal care.

H. Discuss meal preparation and serving in a client's home.

I. Identify key points in meeting nutritional needs of clients with special problems.

J. Modify feeding technique as appropriate for a client's condition.

K. Discuss the nurse assistant's role in providing alternate methods of nutrition.

Key Terms:

- Dysphagia
- Intravenous infusion
- Central line
- Hyperalimentation
- Nasogastric (NG) tube
- Gastrostomy (G) tube

The act of feeding a client is not the only consideration in maintaining nutrition. The preparation of the client for a meal and how the tray is served can influence the client's appetite. The care provided to the client after a meal can make the difference between having it be seen as a pleasant, memorable occasion that the client looks forward to repeating or an uncomfortable experience that the client would rather avoid. From the preparation for a meal, to assisting or actually feeding the client, to the care provided after a meal, the nurse assistant can make mealtime enjoyable.

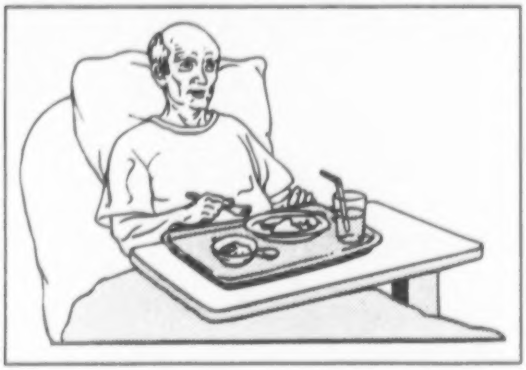
General Considerations in Preparing Clients for Meals

Before the meal is served, the nurse assistant should make sure the client is prepared to eat. Since it is difficult to concentrate on eating when the bladder is full, the client should be offered the bedpan or urinal or assisted to the bathroom prior to the meal. The client's hands should be washed before he or she is taken to the dining room or before the meal tray is brought to the room. Dentures should be clean and placed in the client's mouth. The client should also have other sensory aids in place, such as glasses and hearing aids, to assist with increasing sensory input. Client's are more likely to eat well if they can see the food and hear the sound of pleasant conversation or music.

The client may be served in a variety of settings. In long-term care facilities, clients will usually eat in a dining room. They should be assisted to their place at the table in advance of the meal so that they can relax prior to eating. Their clothing should be protected with napkins or specially designed clothing protectors. The nurse assistant should NEVER refer to these as "bibs" as this can be humiliating to the client. If a client is unable to go to the dining room, the preferred position for the meal is in a chair with an overbed table placed conveniently and comfortably over the chair. In the hospital setting, the client may be placed in a chair at the bedside with the overbed table in place or may eat in bed. If the client eats in bed, the head of the bed should be elevated as high as the client can tolerate, in as close to a sitting position as possible, with the overbed table positioned over the client; this positioning is illustrated in Figure 1.1. In the home setting, the strength of the client will determine where it is most appropriate to serve the meal. Some clients will be able to walk to the table, others will be able to sit at the side of the bed, and others will need their meals served in bed.

Clients look forward to mealtime. Food is a source of comfort for many people. In long-term care, the meal also gives the client an opportunity to socialize. Every effort should be made to ensure that mealtime is a pleasant occasion. The nurse assistant may need to assist in initiating conversation by introducing topics for discussion, such as the weather, current events, or upcoming holidays. Mealtime can also provide an opportunity to enhance orientation through discussions of issues appropriate to the time, such as work-related issues around Labor Day.

Figure 1.1 - Correct In-Bed Eating Position



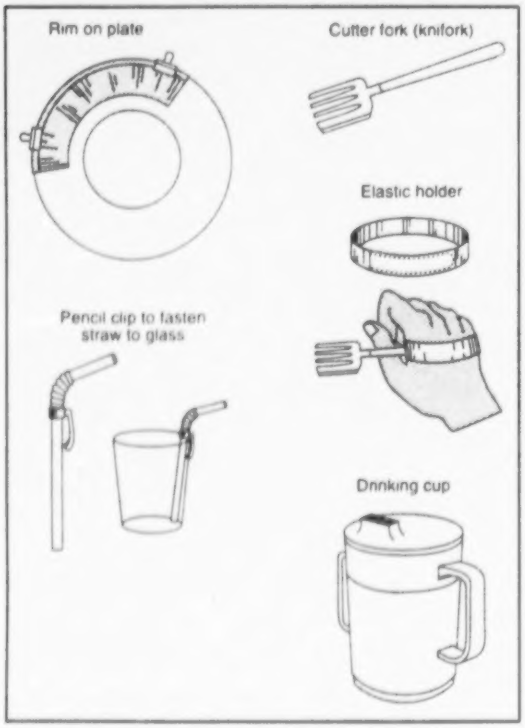
Whatever the setting in which the client is fed, unsightly equipment, such as bedpans, urinals, and emesis basins, should be removed. If the client has recently had a bowel movement, the room should be aired or sprayed with a deodorizer to remove the smell. A fresh glass of water should be within the client's reach, and linens should be straightened so that the client feels comfortable.

Serving Trays

When serving meals on trays to clients, the name and room number on the tray should be checked before the tray is taken to the client. Each client should have a menu or a menu card that can be used to check that all the items are provided on the tray. The trays should be served promptly on arrival so the food is the proper temperature. Trays are served one at a time to prevent contamination of food. They are carried at waist level, not on the shoulder next to the hair. If the client cannot eat when the tray is served, it should be placed back in the serving cart or kept warm in some way.

The general appearance of the tray should be neat and orderly. The client should be assisted with the tray as soon as it is delivered. The tray is placed with the main dish closest to the client. Items on the tray are arranged so the client can reach them. Food covers are removed and placed out of the way or taken back to the kitchen or the serving cart. Before leaving the client, the nurse assistant should deal with milk cartons, cereal boxes, or any items that may be difficult for the client to open. He or she may also need help with cutting food, buttering bread, or pouring liquids. The client may find it easier to use a straw in liquids rather than lift a cup, glass, or soup bowl. Clients should be encouraged to do as much as possible for themselves but not

Figure 1.2 - Adaptive Eating Equipment



allowed to become so exhausted that they have no energy to eat. Some clients can feed themselves using adaptive equipment, such as built-up handles on utensils, plate guards, and drinking cups. Different types of adaptive equipment are pictured in Figure 1.2. Clients should not be left alone until the nurse assistant determines that they can manage on their own.

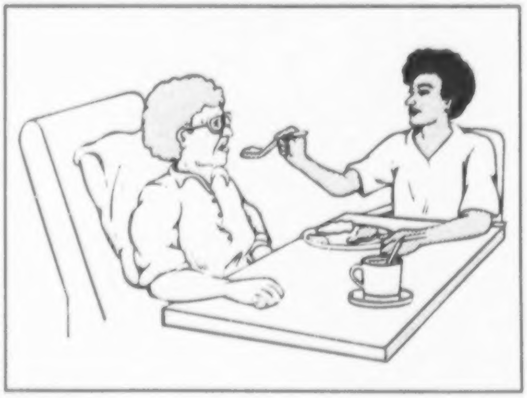
In a home setting, Meals on Wheels are often cold when they are delivered. They should be reheated for the client. The meal may be moved from the Styrofoam container in which it is delivered to the client's regular dishes.

Feeding a Client

If a client cannot manage to eat on his or her own, the nurse assistant will need to feed the client, as shown in Figure 1.3. The tray should be placed where the client can see the food. The client and bed linens should be protected with a towel or napkin. To promote good body mechanics and to encourage socialization while feeding, the nurse assistant should sit beside the client.

Clients who require feeding should not be rushed. They should be given sufficient time for chewing, swallowing, and breathing. Those who are weak will need periods of rest between bites. Clients should be encouraged to feed themselves as much as possible, such as holding a piece of bread. For clients who have problems lifting and/or holding a glass or cup, a straw can be placed in the drink. The client often has enough strength to bend forward and access liquids independently through the straw. Food should be served in the order of the client's preference; if the client is unable to identify the order he or she prefers, liquids and solids should be alternated to provide moisture for chewing. The spoon or fork should be filled about half full to permit the client to manage the food in his or her mouth and to prevent spilling. Clients who are capable of indicating their preference should be asked about seasoning of food. If hot foods are being offered, the client should be warned in advance that the food may be hot. Conversation should be offered during the meal since meals are usually a time for socialization and talking makes the meal more pleasant. The client's mouth may

Figure 1.3 - Feeding a Client



need wiping at intervals during the feeding.

After-Meal Care

The amount of food the client eats and the types of foods consumed should be noted before the tray is removed. Dirty dishes should not be left in front of clients but should be taken away as soon as possible after they have finished eating. The client may wish to wash his or her face and hands after eating a meal and so should either be taken to the bathroom or provided with washcloths. Oral care is also given after a meal. Clients should be checked to make sure their clothing is clean and free from spills. Those clients who are ambulatory or in a wheelchair should be assisted to whatever activity they wish to be involved in after the meal. Clients who are weak or ill should be assisted back to bed and made comfortable; the call light should be left within reach. Clients who are already in bed should be lowered to a comfortable position with personal articles placed where they can reach them.

Steps of Procedure for Feeding a Helpless Client

1. Wash your hands.
2. Provide before-meal care: offer the client a bedpan or urinal; wash the client's hands and face; position the client in a sitting position.
3. Wash your hands.
4. Check the food tray before serving to make sure it is the correct one.
5. Place the food tray in front of the client on an overbed table.
6. Explain that you will help the client eat.
7. Spread the napkin or towel to protect clothes and linen.
8. Sit down in a chair facing the client.
9. Prepare the food: cut up meat, butter bread, pour tea or coffee, etc.
10. Season the food as the client wishes within his or her dietary guidelines.
11. Ask the client in what order he or she wants the food served; name each mouthful of food as you offer it.
12. Let the client do as much as possible.
13. Use straws or a double-handled cup for liquids.
14. Warn the client when serving something hot.
15. Use a spoon to give small bites and feed the client slowly, allowing time for chewing, swallowing, and breathing.
16. Alternate liquids and solids.
17. Wipe the client's mouth as needed.
18. Take the tray away as soon as the client is finished.
19. Note the foods and amounts eaten.
20. Provide after-meal care: wash the client's hands and face; remove napkin; make the client comfortable; place the call device within reach.
21. Wash your hands.
22. Record pertinent observations and report anything unusual to supervisor.

Meal Preparation and Serving in a Client's Home

A home health aide may be required to purchase foods and prepare meals for the client. Meals should be planned with either the client's or a family member's input. Foods that the client has on hand should be identified before any grocery shopping is done. A shopping list should be prepared and discussed with the client. If the client is on a special diet, the requirements of the diet, as well as his or her likes and dislikes, should be taken into consideration. Receipts for purchases should be saved and returned to the client along with any change.

Meals should be prepared with the following principles in mind:

- **Variety** - Using different kinds of foods gives the essential nutrients needed for good nutrition.
- **Flavor** - Strong and mild foods will balance one another.
- **Taste** - Each person has preferences in regard to the spices and the cooking method that most appeals to him or her, such as boiling, broiling, baking, steaming, or frying.
- **Texture** - combining crisp and smooth textures in one meal adds variety to the meal.
- **Color** - Appetite is enhanced by the food's visual appeal.
- **Cost** - Meals planned should be within the client's food budget.

Resources may be available in the community that would assist in meeting the nutritional needs of the homebound. Meals on Wheels can be requested by those who qualify. A minimal fee may be charged for such services. If the client is not homebound, nutritional sites in the community may be able to be accessible to him or her, either by public transportation or special transportation services. Again, a minimal fee may be required. If the home health aide is present at the time Meals on Wheels makes a delivery and the client is not ready to eat at that time, the food should be stored appropriately. If a meal has been delivered prior to the home health aide's arrival and he or she is responsible for feeding the client, food should be reheated to the proper temperature.

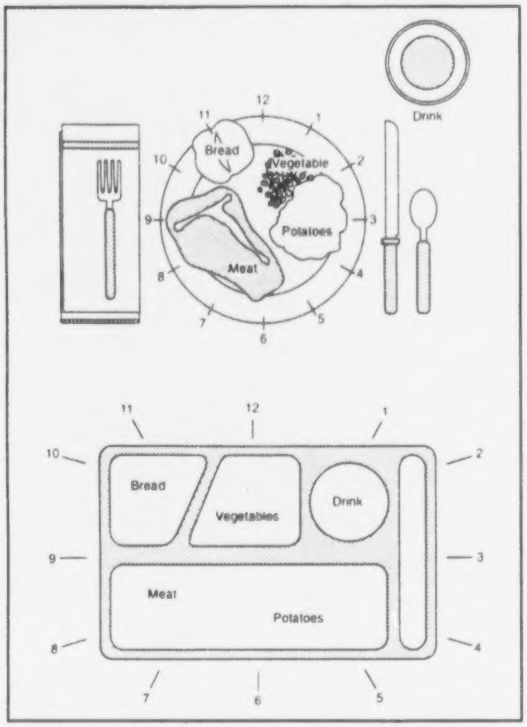
Feeding Clients with Special Problems

A client who has paralysis on one side of his or her body or a weakness of the muscles used for chewing and swallowing must be placed in a sitting position so that gravity aids in swallowing. The client is also less likely to experience the gag reflex in the sitting position. If the client has a weak or paralyzed side, the nurse assistant should place the food in the side of his or her mouth that is NOT paralyzed. The client may need to be reminded to chew and swallow. Small amounts of food should be given with each bite and plenty of time allowed for the client to chew and swallow. The paralyzed side of the mouth may need to be cleaned out frequently.

Difficulty swallowing is known as **dysphagia**. It can occur due to the aging process, which may weaken the muscles responsible for chewing and swallowing, or because of diseases that affect the mouth and throat. To facilitate swallowing for the client with dysphagia, the neck should be flexed, never extended. Close observation is needed to make sure the client actually swallows. If there is no rise and fall of the Adam's apple and verbal encouragement to swallow is not successful, the client's throat can be gently stroked in an attempt to stimulate the swallowing reflex. Liquids may cause a client with dysphagia to choke and aspirate. They are sometimes thickened to the consistency of honey or pudding so the client can feel them and initiate swallowing.

The client who is blind can usually eat independently if good explanations are given. All the food on the tray should be identified. The placement of items can be compared to the positions of the numbers on the face of a clock, as illustrated in Figure 1.4. Items should consistently be

Figure 1.4 - Placement of Food in Relation to a Clock Face



placed in the same place at each meal. For example, the beverage should always be placed in the one o'clock position. The client should be warned which foods are hot and which are cold. He or she should know where the utensils are placed on the tray, and cartons should be opened and food prepared as described in the section on serving. If the client must be fed, he or she will need to be told when a bite of food is being offered and what the food is. The client will also need to be told if a liquid is being given with a straw.

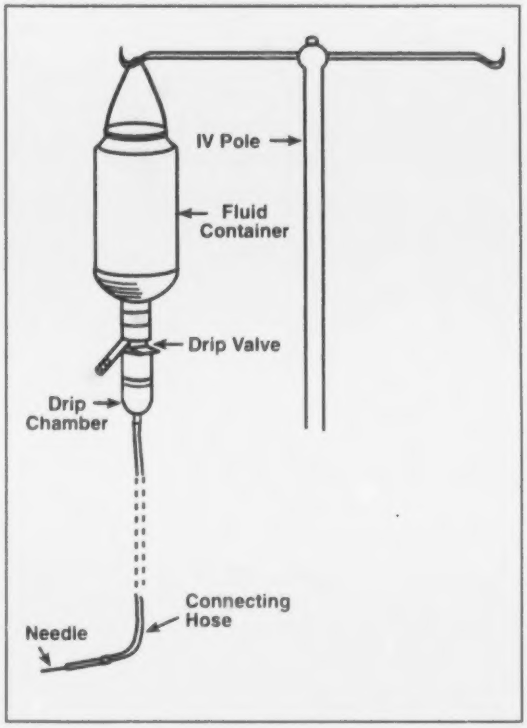
A facility will have special procedures for serving trays to clients in isolation. If the nurse assistant is unsure how to serve the tray, he or she should ask before taking any food or utensils into the room. Paper dishes and disposable trays may be used by the facility. If regular utensils and china are used, special procedures for handling them may be required before they are taken from the room.

Alternate Methods of Nutrition

The client who is comatose, unconscious, or unresponsive cannot be given liquids or food orally but must receive nutrition by another method. An **intravenous infusion** is a direct entry of fluid into a vein by means of a needle. The needle is attached to tubing leading to a bag or bottle of fluid (Figure 1.5). The fluid is ordered by the physician and contains essential nutrients, vitamins, or medications as needed by the client. The fluid drips continuously, either by gravity or through an electronically monitored pump at a rate ordered by the physician. The supervisor monitors the rate.

The nurse assistant should report to the supervisor immediately if the drip has

Figure 1.5 - IV System

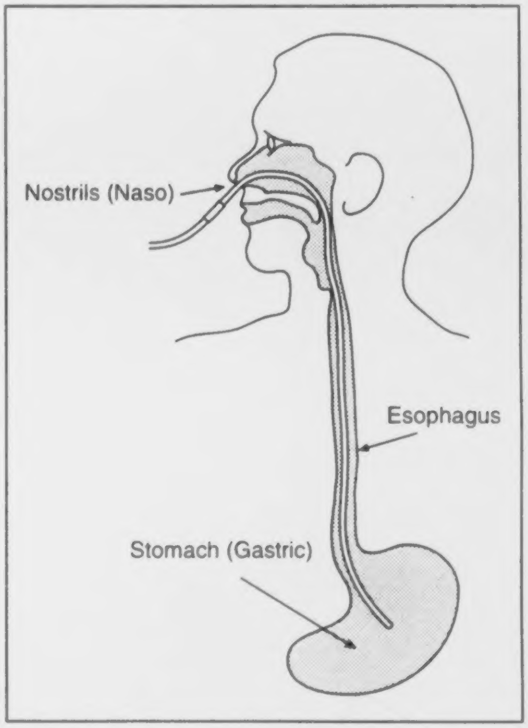


stopped or if it seems to be running unusually fast. Other signs to report to the supervisor are pain, swelling, or redness at the insertion site; changes in respiration or complaints of chest pain, restlessness, or anxiety; and leaks in the tubing. The nurse assistant should make sure the tubing has no kinks and that the client is not lying on it. The bag or bottle containing the fluid must remain above the level of the client's heart. When the fluid level drops to the neck of the bottle or bag, the supervisor should be notified so a new fluid container can be administered. If the IV is on a monitor, the alarm will sound when the tubing is blocked, the fluid container is almost empty, the pump is unplugged, or the battery is about to run down (if it is on battery power). If the alarm sounds, the supervisor should be notified immediately. If the needle is accidentally pulled out, place pressure on the insertion site and immediately call the supervisor.

Intravenous infusions that are used for a short period of time are usually inserted into a peripheral vein. If the client will need the IV for a long period of time, it is usually inserted into a large vein, such as the subclavian or the superior vena cava. When these types of sites are used, the IV is called a **central line,** and **hyperalimentation**, a highly concentrated solution of nutrients, can be given.

Nutrients can also be given through a **nasogastric (NG) tube,** a tube passed through the client's nose and down the esophagus to the stomach (Figure 1.6). Liquid nourishment can be given through the tube either continuously or intermittently. A mechanical pump can also be used with nasogastric feeding to ensure proper drip rates. The alarm will sound if there is any blockage of the tube or the container is empty. The client with a nasogastric feeding tube should be in a sitting position when the feeding is administered; if the feeding is continuous, a semi-Fowler's position (on back with head of bed raised to a 45° angle) is used to aid the digestive process and prevent choking on any regurgitated stomach contents. The client should be observed for nausea, diarrhea, constipation, or complaints of feeling full. The tubing should be free of kinks and the client should not be lying on any portion of it. The feeding bag must be kept above the level of the stomach. Clients with nasogastric tubes in place will often complain of discomfort where the tube rubs against their nose. A water-soluble lubricant can be used to provide comfort; the tube should be taped securely in a position to prevent as much rubbing as possible. Oral care should be provided to increase the client's comfort. If the tubing is accidentally pulled out, the supervisor should be notified immediately.

Figure 1.6 - NG Tube System



A **gastrostomy (G) tube** is a tube that is surgically inserted directly into the client's stomach for the purpose of delivering liquid nourishment. A G tube is often used when a client can no longer swallow and needs an alternate method of receiving nutrients for a long time or the rest of his or her life. The liquid is administered in much the same way as it is through the nasogastric tube. Feedings are usually intermittent, and the gastrostomy tube is plugged when unused. The client should be observed for nausea, diarrhea, constipation, or complaints of feeling full. The feeding bag must be kept above the level of the stomach. If the G tube is accidentally pulled out or is found outside the body when care is initiated, the supervisor should be notified immediately. Home health aides may have to feed a client through a G tube and should always check the position and condition of the tubing. The skin around the tube must also be checked frequently for breakdown due to the leakage of liquid.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 1: Preparing the Client for Meals: Serving, Feeding and Monitoring

Activity Sheet

1. List four things that should be done to prepare clients for meals.

   a. ____________________
   b. ____________________
   c. ____________________
   d. ____________________

2. If clients are unable to get out of bed to eat, what position is best for them?

   ____
   ____

3. List six things that should be done to serve trays properly.

   a. ____________________
   b. ____________________
   c. ____________________
   d. ____________________
   e. ____________________
   f. ____________________

4. List five things that should be done when feeding a client who is helpless.

   a. ____________________
   b. ____________________
   c. ____________________
   d. ____________________
   e. ____________________

5. What things should be done to complete after-meal care?

a. ______

b. ______

c. ______

d. ______

e. ______

f. ______

6. What are the six principles by which meals are prepared when working in home health?

a. ______	d. ______
b. ______	e. ______
c. ______	f. ______

7. What special techniques are used when feeding a client who has paralysis or weakness of one side of the body?

a. ______

b. ______

c. ______

d. ______

e. ______

f. ______

8. What special techniques are used when serving and/or feeding a client who is blind?

a. ______

b. ______

c. ______

d. ______

e. ______

f. ____

g. ____

h. ____

9. What should be done when serving clients in isolation?

10. What is an intravenous infusion, and what are the nurse assistant's responsibilities during the infusion?

    a. ____

    b. ____

11. What should the nurse assistant do for a client receiving nasogastric feedings?

12. What should the nurse assistant do for a client receiving gastrostomy feedings?

____

____

____

____

____

____

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedure for feeding a helpless client, practice it in the laboratory setting with a partner by feeding each other lunch.
2. Role-play feeding a client who is blind by describing the contents of a tray to your blindfolded partner. Switch roles.
3. Examine an intravenous infusion pump and a feeding pump.

Lesson 2:
Intake and Output

Objectives:

A. Discuss the importance of fluid balance.

B. Identify the routes by which fluid is taken into the body.

C. Distribute drinking water.

D. Identify the routes by which fluid leaves the body.

E. Discuss the general considerations in measuring intake and output.

F. Measure and record intake and output.

G. Convert household measurements to metric equivalents.

H. Describe what is meant by frequent fluids and methods by which this can be accomplished.

I. Describe what is meant by restricted fluids and methods by which this can be accomplished.

Key Terms:

- Fluid intake
- Fluid output
- Edema
- Dehydration
- Intake and output record (I & O sheet)
- Graduate or graduated cylinder
- Frequent fluid
- Restricted fluids

While water is not a nutrient, water is necessary for the human body to complete all its chemical processes. The body must maintain a balance between the fluid ingested and the fluid eliminated to remain healthy. People can tolerate going without food for a fairly long time since they can use fat stores and even muscle to produce energy, but they cannot live very long without water. Observing, measuring, and recording fluid intake and output is an important means of monitoring the health of a client.

Fluid Balance

Since the human body is approximately 65 percent water, it is essential to life. Water is taken in through eating and drinking. About 2½ to 3 quarts of water are ingested per day by drinking liquids and eating foods that are high in fluid content, such as fruits and vegetables. The ingestion of water is referred to as **fluid intake**. About the same amount of fluid is eliminated from the body daily in the form of urine, perspiration, feces, and moisture exhaled from the lungs during respiration; this elimination of fluid is referred to **fluid output**. The body has mechanisms by which the fluid intake and the fluid output are balanced. When intake is greater than output, the body stores the fluid in its tissues, resulting in a condition known as **edema**. When intake is less than output, a condition called **dehydration** is the result. When a person is ill, the balancing mechanisms may not work as they should, so intake and output must be monitored so the physician can manipulate either the intake or the output of fluid to help the body regain its balance.

Fluid Intake

Most people take fluid orally when they are healthy. The most obvious sources of fluids are liquids, such as water, coffee, tea, juice, carbonated beverages, milk, and ice chips. Some foods that are primarily liquid are also easy to think of as fluids, such as ice cream, sherbet, soup, and gelatin. These items are all measurable fluids taken orally. Another source of fluid is foods that have a high fluid content.

Another route by which fluid is taken into the body is directly into a vein through intravenous infusion. If the client is unable to eat or drink or has to have medications given directly into the bloodstream, they may have an IV. The bottles or bags of solution usually come in 500 or 1000 cc units. The physician designates the amount to be given in a 24-hour period.

A nasogastric tube or gastrostomy tube carries liquid nourishment directly to the stomach. As described in the previous lesson, these feedings may be given continuously or intermittently. The amount given is prescribed by the physician.

Steps of Procedure for Distributing Drinking Water

1. Wash hands.
2. Check with the charge nurse to identify which clients are not allowed water.
3. Check the care plan to identify the clients who do not want or are not allowed ice.
4. Collect pitchers, glasses, and trays from the bedside of clients and place them on a cart or tray.
5. Take the cart or tray of equipment to the dietary department or clean utility room.
6. Obtain clean pitchers and glasses.
7. For clients allowed ice, fill pitchers ⅓ full of ice; use ice tongs or a large spoon to handle ice.
8. Add water to fill pitchers.
9. Return pitchers promptly to clients' bedside tables.

In the home setting, the client's water pitcher can be washed at the kitchen sink and refilled. Make sure to check to see if client can have liquids before filling pitcher. Some clients may have tests scheduled that require nothing by mouth before the exam.

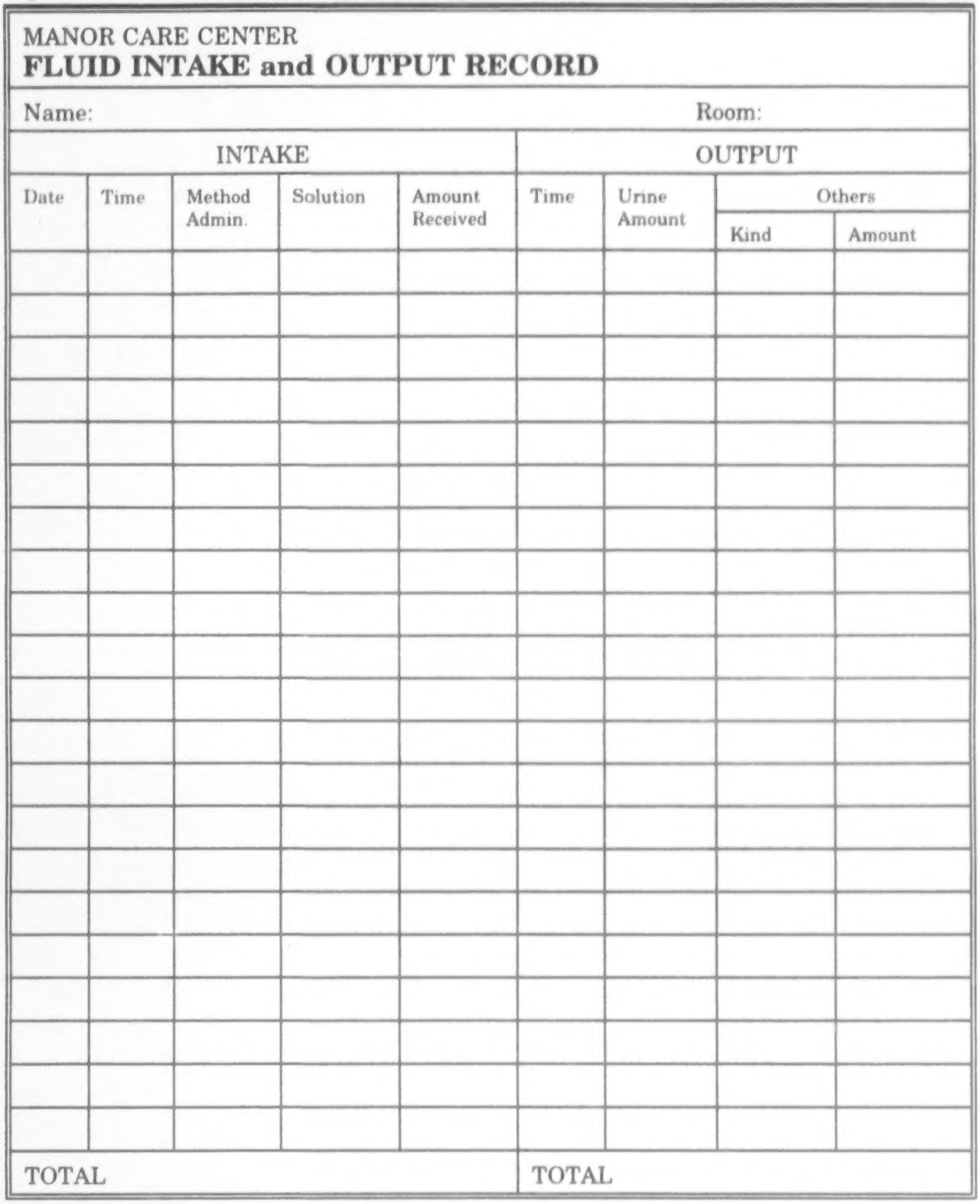
Fluid Output

The first thing that people think of when fluid output is mentioned is urine. Most fluid is eliminated from the body in this form. If the client is able to void in a container or has a catheter, liquid output is easily obtained for measurement. All other body fluids are also measured when fluid intake and output must be monitored. These include emesis, diarrhea, drainage from a wound, and diaphoresis (profuse sweating). These types of fluids may be much more difficult to measure, and the amounts must be estimated in some instances.

General Considerations in Measuring Intake and Output

A form, the **intake and output record**, or **I & O sheet**, should be present at the client's bedside when intake and output are measured. An intake and output sheet is shown in Figure 2.1. Any time liquid is ingested or fluid eliminated, the amount should be recorded immediately. Most fluids are ingested at mealtimes, so the nurse assistant will need to check the meal tray before it is taken away. The amounts of all fluids eliminated should also be

Figure 2.1 - Fluid Intake and Output Record



MANOR CARE CENTER

FLUID INTAKE and OUTPUT RECORD

Name: Room:

INTAKE					OUTPUT			
Date	Time	Method Admin.	Solution	Amount Received	Time	Urine Amount	Others	
							Kind	Amount
TOTAL					TOTAL			

1 Ounce = 30 cc 8 oz. Glass = 240 cc 4 oz. Juice Glass = 120 cc

*4 oz. Soup Bowl = 120 cc 6 oz. Cup = 180 cc *Jell-O™-4 oz. = 120 cc

*Measure servings in each facility to establish an accurate measure.

recorded on the sheet as soon as they are obtained. Intake and output are totaled at the end of each shift and at the end of the 24-hour period.

The client should keep track of how many glasses of water he or she has drunk from the bedside water pitcher. If the client is incapable of keeping track, the water remaining in the pitcher should be measured to determine the amount. For most water pitchers, the amount contained in the pitcher can be determined by looking at the amounts marked on its side (see Figure 2.2).

The container used to measure any type of intake should be different from the container used to measure output. Fluids should always be measured in a rigid container. Plastic catheter bags that have amounts indicated on the side are not always accurate, so the urine should be drained into a **graduate** or **graduated cylinder** (a tall narrow container with a volumn scale), to measure the amount. If a transparent graduate is used as a measuring device, it should be read at eye level.

The client should not put toilet paper into the bedpan or receptacle that is used for voiding, since it will absorb some of the urine, preventing an accurate output measurement from being made. If the client is incontinent, the number of times the client voids is recorded on the I & O. Output in the form of emesis that is not caught in an emesis basin, wound drainage on dressings, and perspiration are also difficult to measure exactly. The number of times it occurs, the size of the area that is wet, and the wetness of the linens, clothing, or dressings are all ways that unmeasurable fluid loss can be recorded to give some approximation of the amount of fluid lost.

Figure 2.2 - Marked Water Pitcher

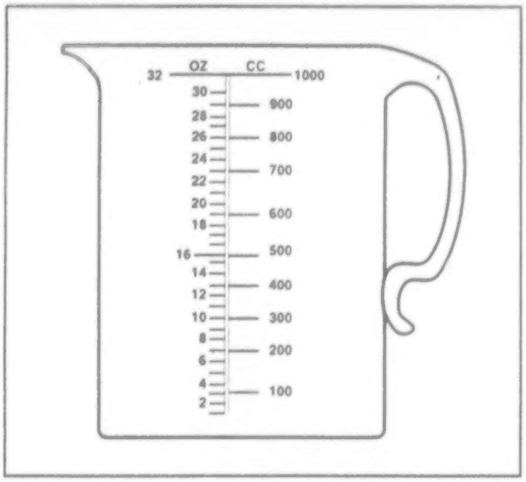


Figure 2.3 - Common Container Sizes

Water pitcher . . .	1 quart or 1,000 cc
Coffee cup	8 oz or 240 cc
Foam cup	8 oz or 240 cc
Water glass	8 oz or 240 cc
Soup bowl	6 oz or 180 cc
Juice glass	4 oz or 120 cc
Jell-O, 1 serving	4 oz or 120 cc
Ice chips	2 Tbsp or 30 cc

All serving containers are different. The home health aide should measure the amount of liquid contained in the most frequently used serving containers. A list of these amounts should be kept to refer to when recording intake. Figure 2.3 is a listing of the most common container sizes used in health care facilities.

Intake and output should be recorded in the same units. The most frequent designation is cubic centimeters, or cc. The measurement equivalents were given in the Health Care Assistant Core. Figure 2.4 shows equivalent measurements for converting from household measurements (which are recorded in ounces) to the metric system.

Figure 2.4 - Measurement Equivalents

1 ml = 1 cc
1 tsp = 5 cc
1 oz = 30 cc
1 pt = 500 cc
1 qt = 1,000 cc

In the home setting, the client can be taught to record intake and output. Family members or other care givers can also be taught to carry out this task. The recorded information should then be transferred to the home health aide's report for inclusion in the home health record.

Steps of Procedure for Measuring Fluid Intake

1. Obtain a list of the most commonly used fluid containers in the facility or home.
2. Wash hands.
3. Identify self.
4. Identify client.
5. Explain to the client how he or she can assist by writing down the amount and kind of fluids taken (if the client is able to do so).
6. Have a form for recording intake and output available.
7. Measure and record all fluids consumed by the client during the shift.
    a. Record intake after each meal before the tray is removed.
    b. Record other intake as it is consumed.
8. Wash hands.

Steps of Procedure for Measuring Fluid Output

1. Identify the client.
2. Identify self.
3. Explain how the client can assist by capturing all output in a bedpan or other measuring container.
4. Have a form available for recording output.
5. Wash hands.
6. Put on gloves.
7. Using a measuring container, measure each void, liquid stool, emesis, or other liquid output.
8. Discard output in toilet.
9. Rinse the measuring container.
10. Dispose of the gloves.
11. Wash hands.
12. Record output on form.

Frequent Fluids

Frequent fluids means that a client is encouraged to ingest more than his or her normal fluid intake. The client can drink too much, so the nurse assistant should know the amount of fluid that the client is to have within a 24-hour period. When a client is on a frequent fluids order, fluids should be placed within reach, with small amounts offered frequently. Clients sometimes drink more readily when their favorite beverages are offered and when a variety of fluids are available. A goal for the amount of fluid to be ingested during each shift should be established and communicated to the client. If the client has difficulty reaching the fluid goal by drinking, foods high in fluid content, such as watermelon, pudding, Jell-O™, and Popsicles™, can be offered.

Restricting Fluids

When the client is on **restricted fluids**, the amount of fluid that should be ingested is limited to a certain amount, which is usually ordered by a physician. The nurse assistant should know the total amount of fluids that are allowed for the 24-hour period. The total is usually divided between the three shifts, with the day and evening shift being allotted the greatest amount of fluid. The night shift may be allotted a very small amount if the client needs to take medication or may not be allotted any fluid at all. The amount of fluid allotted for a shift should be distributed throughout the entire shift, taking into account that more fluids are needed at mealtime to moisten food for swallowing and digestion. Frequent oral hygiene should be offered to keep the mouth moist, which sometimes keeps the client from craving fluids. The client may be allowed to suck on ice ships to provide continual moisture without giving a great deal of fluid. Hard candy can also be used. The supervisor should be consulted before either of the last two measures are taken.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 2: Intake and Output

Activity Sheet

1. What happens when fluid is not balanced in the body?

____

____

2. What are the routes by which fluid is taken into the body?

   a. ____

   b. ____

   c. ____

3. What are the routes by which fluid is eliminated from the body?

   a. ____________________ d. ____________________

   b. ____________________ e. ____________________

   c. ____________________

4. Where is intake and output for the client recorded?

____

5. What type of container should be used for measuring fluid output such as urine?

____

6. If the output cannot actually be measured, what can be done to give an approximation of the amount of fluid being eliminated?

____

____

____

____

7. How can the home health aide know how much the serving dishes used for the client hold?

8. What is the most frequent designation of units for recording intake and output?

9. What does "frequent fluids" mean?

10. List three of the techniques that will help in giving frequent fluids.

    a.

    b.

    c.

11. What does "restricted fluids" mean?

12. List three of the techniques that will help in restricting fluids.

    a.

    b.

    c.

Clinical/Laboratory Activities

1. Using a sample intake and output record provided by the instructor or clinical supervisor, record the following in the appropriate places on the record:

   Intravenous infusion - 230 cc
   Water - 60 cc
   Apple juice - 40 cc
   Broth - 120 cc
   Catheter drainage - 450 cc
   Wound drainage - 20 cc
   Ice chips - 30 cc

2. Total the amounts for the 8-hour shift.

3. Determine if the client has achieved fluid balance. Why or why not?

   ____

   ____

4. Using household measures, make a list of how much the following items in your kitchen cabinet hold:

   a. Coffee cup ____________
   b. Mug ____________
   c. Juice glass ____________
   d. Drinking glass ____________
   e. Soup bowl ____________

5. Convert the household measures obtained in #4 to metric equivalents.

   a. ____________
   b. ____________
   c. ____________
   d. ____________
   e. ____________

6. After receiving instruction, practice the following procedures:

   a. Distribute drinking water
   b. Measure fluid intake
   c. Measure fluid output

Lesson 3:
Weight and Height

Objectives:

A. Describe the types of scales that can be used to weigh clients.

B. Identify general considerations in weighing clients.

C. Convert a measurement of pounds into kilograms and one of kilograms into pounds.

D. Identify general considerations in measuring height.

E. Convert a measurement of inches into feet and inches and one of feet and inches into inches.

F. Measure client's weight and height.

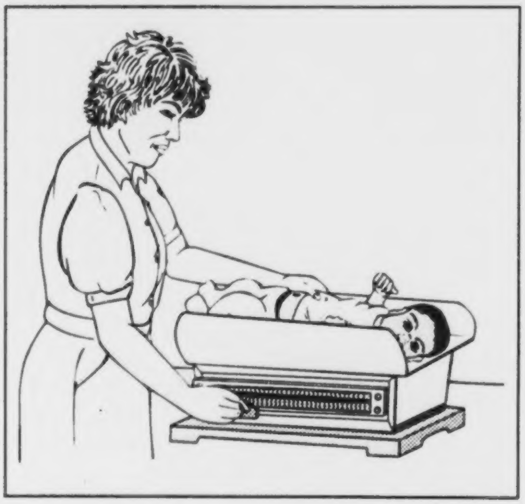
G. Measure weight and length of infant.

Key Terms:

- Infant scale
- Bathroom scale
- Upright scale
- Wheelchair scale
- Chair scale
- In-bed scale

Measuring height and weight may seem unimportant, but these measurements can provide valuable information about the client. Weight can be an indicator of the nutritional status of the client. Increased weight may also be an indication of medical problems that result in retention of body fluids. Height and weight can be used to determine whether a child is growing and developing according to the normal pattern. Dosages of medications may also be ordered based on body weight.

Figure 3.1 - Infant Scale



Types of Scales

Many types of scales can be used for clients, depending on their degree of mobility and their size. Weighing an infant requires an **infant scale**, which is a type of balance scale with a platform large enough to hold an infant. An infant scale is illustrated in Figure 3.1. A **bathroom scale**, shown in Figure 3.2, is

Figure 3.2 - Bathroom and Upright Scales

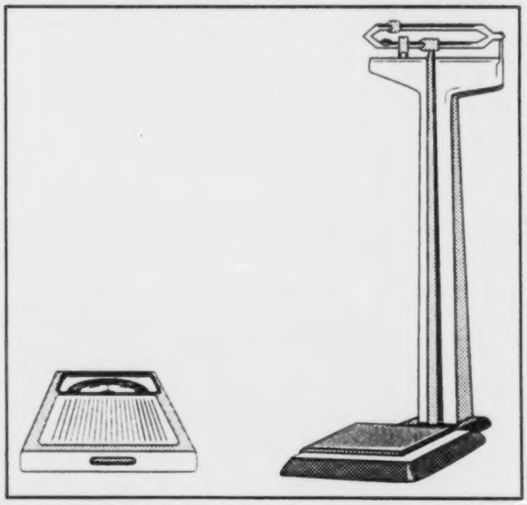
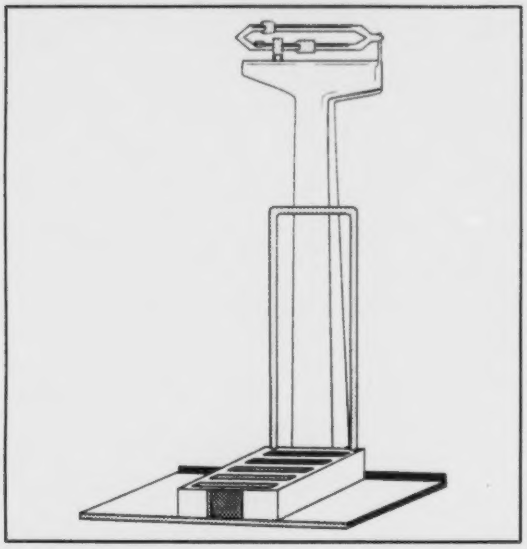


Figure 3.3 - Wheelchair Scale



used in the home to weigh a client. Most health care facilities use **upright scales** for weighing ambulatory clients. This type of scale, which is also pictured in Figure 3.2, has a platform on which the client stands; the weight indicators are moved until the scale balances. A **wheelchair scale** is a special type of upright scale that has a platform large enough to accommodate a wheelchair. The wheelchair is rolled onto the platform, and the scale is balanced just as on the upright scale. A wheelchair scale is shown in Figure 3.3. A **chair scale** has a chair in which the client sits; it may be either a balance or an electronic scale. A modification of the chair scale allows the client to assume a reclining position. This type of scale can be used for clients who are unable to balance in a sitting position. An **in-bed scale** is used for those clients who must remain on bed rest or whose condition does not allow them to be transferred out of the bed. Mechanical lifts can also be fitted with an electronic weighing device.

General Considerations in Weighing Clients

Accuracy in weighing clients is essential since the physician may order medications and treatments based on the client's weight. A baseline weight measurement is obtained when the client is admitted to a health care facility. For the home health care client who has a problem with his or her nutritional status, the home health aide may need to weigh the client on a bathroom scale (if the client's condition permits) when the case is assigned. Scales do vary, so the same scale should be used every time the client is weighed. A client's weight may vary during the day, so the procedure should be performed at the same time each day. The best time to weigh clients is in the morning after they have urinated and before they have had anything to eat or drink. Clients should have their shoes or slippers off and have on as little clothing as possible. The type of clothing clients wear should be the same every time they are weighed. An infant is usually weighed without clothing or diapers. If the client has a brace or artificial limb, the device should be weighed and that weight subtracted from the total weight. If a client has on a device that cannot be removed or if the client refuses to remove it, a note should be made that the weight of the client includes the device. When a wheelchair scale is used, the wheelchair is weighed first, then the client is brought to the scale in the wheelchair, and both are weighed. The weight of the wheelchair is then subtracted from the total weight.

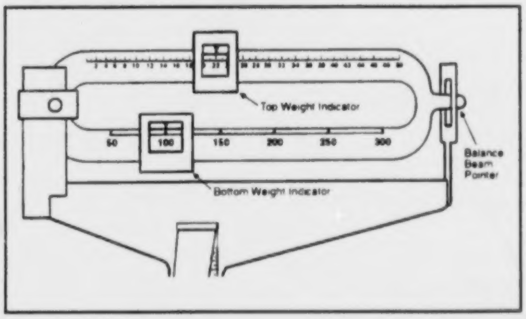
Clients in long-term care are weighed at least once every month. The previous weight should be noted as the current weight is being recorded, and a gain or loss of five pounds or more should be reported to the supervisor. Clients in the hospital or the home may be weighed daily as an indicator of fluid lost or retained. The daily weight should be reported to the supervisor.

A balance scale has two weight indicators, as shown in Figure 3.4. The large weight indicator is located at the bottom and is marked in increments of fifty pounds. The small weight indicator is at the top and is marked in smaller increments of pounds. These two indicators will need to be added together to give an accurate weight. Most balance scales are marked in pounds. A digital or electronic scale may give the weight in either pounds or kilograms. To convert from kilograms to pounds, multiply the weight in kilograms by 2.2. To convert from pounds to kilograms, divide the weight in pounds by 2.2.

To maintain safety, clients should be assisted onto upright or bathroom scales. If there is any question about a client's ability to maintain his or her balance on an upright or bathroom scale, another type of scale should be used. Clients on chair or wheelchair scales or in mechanical lift or bed scales should not be left alone and should be taken off the scale as soon as the weight is recorded. The nurse assistant should always keep a hand close by infants when they are being weighed.

When weighing the client in the home health setting, the device the client has available in the home should be used. This is usually a home bathroom scale, which can only be used if the client is mobile enough to step up onto the scale. Safety should also be considered; the client must be able to maintain his or her balance on the scale long enough for the reading to be taken. If weight is a concern and the client has no device in the home, the home health aide may need to carry a bathroom scale to the visit.

Figure 3.4 - Balance Scale



General Considerations When Measuring Height

For adult clients, the most common method of obtaining a height measurement is the client's verbalization of such. If the client is unable to respond, then one of the following methods can be used. If the client is unable to stand on an upright scale, the height can be measured while he or she is lying in bed. The client should be placed in a supine position with the bed flat. The nurse assistant should position one end of a tape measure on the bed parallel to the top of the client's head and pull the tape down the length of the body to the soles of his or her feet. If the client cannot be placed in a flat position and a height measurement is necessary, an approximate height can be obtained by extending the arms out to the sides at the shoulder and measuring from the tip of the third finger of one hand across the body to the tip of the third finger of the other hand.

Upright scales have a scale measuring height attached to the back. The client stands on the platform facing away from the scale. The height is measured in inches on the scale with the long lines indicating inches and the short lines indicating quarter inches. One foot is equal to twelve inches. To convert from inches to feet, divide the number of inches by twelve. To convert from feet to inches, multiply the number of feet by twelve.

An infant may be measured using a tape measure as described above, or the infant scale may have a measuring device on it. If a measuring device is present on the scale, the infant is placed in a supine position with his or her head against the metal plate at the top of the scale. The nurse assistant should place one hand over the infant's trunk and the other over the legs to straighten the infant to his or her complete length.

Steps of Procedure for Measuring Weight and Height on an Upright Scale

1. Wash hands.
2. Assemble the necessary equipment.
3. Identify and greet the client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy.
7. Place a paper towel on the scale platform.
8. Raise the measuring rod.
9. Ask the client to remove his or her robe and slippers; provide assistance if necessary.
10. Assist the client to stand on the scale platform; have the client stand with his or her arms to their sides.
11. Read the weight.
    NOTE: If using a balance scale, move the weight until the pointer swings evenly between the top and bottom of the metal square.
12. Record the weight.
13. Instruct the client to stand erect with his or her back to the measuring rod.
14. Lower the measuring rod until it rests on the client's head.
15. Read and record the height.
16. Raise measuring rod.
17. Assist the client off the platform.
18. Assist the client in putting on his or her robe and slippers.
19. Assist the client to his or her bed or chair.
20. Discard the paper towel.
21. Remove, clean, and store equipment.
22. Wash hands.
23. Make the client comfortable; place the call device within reach.
24. Report unusual occurrences to the supervisor.

Steps of Procedure for Measuring Weight and Length of an Infant

1. Wash hands.
2. Assemble equipment.
3. Prepare scale: balance at zero, cover with tissue paper.
4. Identify infant.
5. Provide privacy.
6. Pick up infant correctly.
7. Remove infant's clothing and diaper.
8. Place infant on scale.
   CAUTION: Keep one hand by infant at all times.
9. Move weight until pointer swings evenly.
10. Read scale.
11. Record weight.
12. If length measuring device is on scale, position infant supine with head touching metal plate. Otherwise place infant on flat surface.
13. Measure length.
    a. If measuring device is on scale, hold one hand on infant's trunk and use the other hand to straighten the legs.
    b. If using a tape measure, place tape measure with zero mark at infant's head. Place other end of tape by infant's heel. Hold one hand on infant's trunk and use the other hand to straighten the legs.
14. Read measuring device at heel.
15. Record length.
16. Dress infant.
17. Return infant to crib or parent.
18. Clean, move, and store equipment.
19. Wash hands.
20. Report unusual occurrences to supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

After you have completed the activity sheets, you may take the written evaluation for this unit. A score of at least 80 percent indicates you may proceed to the next unit. Check with your clinical supervising staff member for skill testing.

Lesson 3: Weight and Height

Activity Sheet

1. Describe the six different types of scales.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

   e. ______________________________

   f. ______________________________

2. Why is accuracy in measuring weight so important?

   ____

   ____

3. Identify five general considerations in weighing a client.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

   e. ______________________________

4. How often are clients in long-term care weighed?

   ____

5. What do the weight indicators signify on a balance scale?

   a. ______________________________

   b. ______________________________

6. What safety factors should be considered when weighing clients?

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

7. If the client cannot be measured on an upright scale, how can height be measured?

   ____

   ____

   ____

8. How is an infant's length measured?

   ____

Clinical/Laboratory Activities

1. Practice weighing yourself on an upright scale.
2. With a partner, practice measuring height on an upright scale.
3. The following are the weight indicators from a balance scale. Determine the client's weight.

   a. 150 and 32 ____________

   b. 50 and 47 ____________

   c. 100 and 19½ ____________

   d. 200 and 30¼ ____________

4. Convert the following weights to kilograms.

   a. 150 lbs. ____________

   b. 97 lbs. ____________

   c. 186 lbs. ____________

   d. 213 lbs. ____________

5. Convert the following weights to pounds.

   a. 52 kg ________________

   b. 48 kg ________________

   c. 30 kg ________________

   d. 86 kg ________________

6. Using a soft doll, practice measuring weight and length of infant.

Unit Checklist

Student Name ______________________ Overall Unit Rating ________

Activity Sheet: Preparing the Client for Meals: Serving, Feeding and Monitoring Rating ________

Comments: ______________________

____

Skill Sheet: Feed a Helpless Client Rating ________

Activity Sheet: Intake and Output Rating ________

Comments: ______________________

____

Skill Sheet: Distribute Drinking Water Rating ________

Skill Sheet: Measure Fluid Intake Rating ________

Skill Sheet: Measure Fluid Output Rating ________

Activity Sheet: Weight and Height Rating ________

Comments: ______________________

____

Skill Sheet: Measure Weight and Height on an Upright Scale Rating ________

Skill Sheet: Measure Weight and Length of an Infant Rating ________

Written Unit Evaluation Score ________

Additional Comments: ______________________

____

____

Teacher Signature ______________________ Date ________

Student Signature ______________________ Date ________

Unit VIII

Special Procedures

The nurse assistant often performs other procedures in addition to the activities of daily living. This unit has been titled "Special Procedures" because these procedures do not fit into the categories of personal hygiene measures, nutritional measures or moving clients. These procedures are necessary for the health and well-being of clients or for diagnostic and treatment measures.

Unit Lessons

Admission, Transfer and Discharge

Urinary Elimination

Bowel Elimination

Ostomies

Specimen Collection

Applying Heat and Cold

Wound Care

Caring for the Terminally Ill and the Deceased

Lesson 1:
Admission, Transfer and Discharge

Objectives:

A. Discuss the emotional impact that admission to a health care facility has on a client and his or her family.

B. Describe the nurse assistant's responsibilities when assisting with admission.

C. Identify the nurse assistant's responsibilities when transferring a client within a health care facility.

D. Discuss the nurse assistant's responsibilities when assisting with discharge of a client.

Key Terms:

- Admission pack
- Baseline assessment
- Transfer
- Discharge

The nurse assistant is responsible to assist the licensed nurse in admission, transfer and discharge of a client. The licensed nurse will delegate the tasks the nurse assistant is to perform.

Emotional Impact of Admission on a Client and Family

Many clients are unfamiliar with the health care environment when they are admitted. They may feel insecure and unsafe. The unfamiliar surroundings may cause confusion in elderly clients.

Clients may also be unsure of what the future holds. They have given up their independence and must rely on health care workers to provide for their basic needs. Clients are not given a choice regarding when meals are served, when tests are scheduled or even when to bathe. Unless a client is experiencing a life-threatening condition, family members will probably not stay twenty-four hours a day, so a client may feel lonely and abandoned. Clients who are admitted to long-term care facilities experience many other losses: homes, possessions, neighbors, social contacts and social roles. These losses may cause them to feel sad, depressed, apathetic, anxious, demanding or even angry. Not only will clients experience the emotional impact of admission, but family members may also have similar feelings.

The nurse assistant should recognize that the behavior of a client and his or her family may be the result of the emotional impact of admission. The nurse assistant should present a caring, concerned attitude and seek to explain everything that is being done. He or she should be tolerant of difficult behavior because it may be the client's way of managing fear.

Responsibilities for Admission

The nurse assistant should prepare the room before a client arrives. The bed should be made, and the room should be neat and clean. The personal supplies that a client might need should be labeled with the client's name. Many health care facilities will have an **admission pack**, which contains items such as a water pitcher, water glass, box of tissues, wash basin, soap, lotion and other items that clients use frequently. Lighting and ventilation in the room should be adjusted for the client's comfort.

When a client arrives, he or she should be greeted warmly. The nurse assistant should introduce himself or herself and find out how the client wishes to be addressed. For example, some clients prefer to be called Mr. Jones or Mrs. Smith. Other clients prefer the health care worker to call them by their first name. Throughout the admission process, a client should be observed closely and any complaints noted to report to the supervisor. The nurse assistant should explain everything that he or she does to a client. If a room is shared, a client should be introduced to his or her roommate. A client should be shown where to place his or her belongings, and the nurse assistant should offer to help with unpacking and storing the items. In long-term care, the nurse assistant will make a list of all the client's belongings. This is kept as a part of the client's record. All items should be marked with the client's name, and each client should put on an identification bracelet. Explanations should be given about how to work the call device, bed, lights, radio and television if the room is equipped with them. Meal schedules, visiting hours and any other pertinent information about the facility should be explained. The nurse assistant can answer questions that a client or family has about these items.

A client's vital signs, height and weight are measured by the nurse assistant. The charge nurse will indicate if specimens, such as urine, stool or sputum specimens, need to be collected. Questions about health status, medical condition, medications or diagnostic exams should be referred to the charge nurse.

All observations and data collected should be reported to the charge nurse. The charge nurse will be responsible for performing a baseline assessment. The **baseline assessment** is the initial assessment and contains basic health information, such as medical diagnoses, medications, reasons for admission and a collection of facts about the body systems pertinent to that individual client.

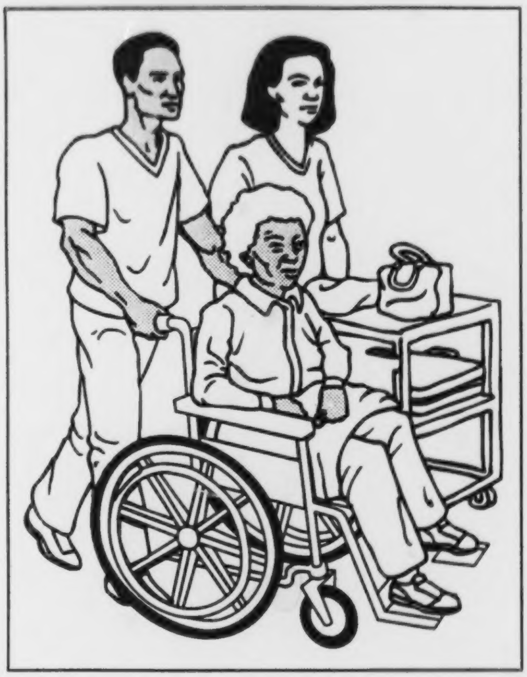
Responsibilities for Transfer

A **transfer** is moving a client from one unit or room to another. Clients may need to be transferred from one unit to another because their condition has changed, because they prefer a different type of room, because they have problems with roommates or because the facility has a legitimate reason for the transfer, such as the renovation of a room. The nurse assistant is usually responsible for packing the client's belongings and assisting the client to move to his or her new room.

Home health care clients may be transferred from their home to a hospital or to a long-term care facility. These transfers usually do not require the home health aide to accompany the client. Treatment should not be disrupted by the transfer. The emotional impact of a transfer can be the same as for an admission, so the reason for being transferred should be explained thoroughly and clients should be given time to cope with their feelings.

The home health aide should assist the client who is being transferred with packing of his or her belongings. The chart and medical records are sent with a client. The charge nurse will be responsible for giving medical information about a client to the new staff. The nurse assistant at the new facility is responsible for introducing the client to the staff.

Figure 1.1 - Discharging a Client



Responsibilities for Discharge

When a client is **discharged,** he or she is released by his or her physician from the health care facility. Clients discharged from a hospital may go home, go to a family member's home or go to a long-term care facility. Clients discharged from a long-term care facility may go home, to a hospital, or to another long-term care facility.

The nurse assistant should assist a client in gathering all personal belongings. All drawers and closets should be checked for personal items. Clients in long-term care facilities may have clothing in the facility's laundry that should be retrieved before they leave the facility. If a client in long-term care is being discharged to a hospital for an undetermined length of time and a room is being held for the client's return, personal belongings may be placed in storage at the long-term care facility.

Clients should be dressed appropriately for the weather. They are usually transported from a facility by relatives, ambulance or transportation services available for persons who are elderly or disabled. The nurse assistant should make sure that all discharge instructions have been given by the charge nurse before allowing a client to leave the facility. If a client is being transferred from a hospital to a long-term care facility or from one long-term care facility to another, transfer papers must accompany the client. A client should not leave the health care facility unassisted. Facilities are responsible for the clients until the moment they enter the means of transportation away from the facility. Nurse assistants are shown in Figure 1.1 assisting a client as she is being discharged.

Each health care facility has its own policy regarding the responsibilities of a nurse assistant in cleaning a unit a client has vacated. Some facilities require that the nurse assistant strip the linen from the bed, remove all equipment and dispose of items the client did not take, such as plants and flowers. The housekeeping staff is usually responsible for disinfecting each unit prior to the admission of the next client.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 1: Admission, Transfer and Discharge

Activity Sheet

1. Describe the emotional impact of admission on clients and family members.

2. What are five responsibilities of the nurse assistant when admitting a client?

   a. ______

   b. ______

   c. ______

   d. ______

   e. ______

3. What are two responsibilities of the nurse assistant when transferring a client?

   a. ______

   b. ______

4. What are three responsibilities of the nurse assistant when discharging a client?

   a. ______

   b. ______

   c. ______

Clinical/Laboratory Activities

1. Working in a group of three or four students, discuss the feelings you had when either you or a family member was admitted to a health care facility. Discuss what could have been done to cause less anxiety and make the experience more comfortable.

2. Simulate an admission of a health care facility. Use an admission form from a local facility. Have one student act as the client and another as a nurse assistant. Inventory belongings, complete vital signs, measure height and weight and orient the client to the health care environment.

Lesson 2:
Urinary Elimination

Objectives:

A. Describe the characteristics of normal urine.

B. Discuss the factors that maintain urine elimination.

C. Identify conditions that may cause abnormal urine elimination.

D. Identify general considerations in giving and removing bedpans and urinals.

E. Assist client with urinal

F. Assist client with bedpan.

G. Discuss the responsibilities of the nurse assistant in managing urinary drainage systems.

H. Change urinary drainage bag.

I. Discuss the nurse assistant's role in bladder training.

J. Change adult incontinent brief.

Key Terms:

- Void or urinate
- Incontinence
- Cystitis
- Hematuria
- Nephritis
- Renal calculi
- Lithotripsy
- Urinary retention
- Bedpan
- Urinal
- Catheter
- Straight or French catheter
- Indwelling or Foley catheter
- External or Texas™ catheter or condom drainage
- Leg bag
- Bladder training
- Incontinent briefs

Elimination of urine is one of the body's basic functions. The body must be able to eliminate excess fluid and waste products as urine to maintain health. To pass urine from the bladder out of the body is to **void** or **urinate**. The elimination of urine is a private function. The nurse assistant should be considerate of a client's feelings while assisting him or her in meeting this basic need.

Normal Urine Characteristics

Urine is normally pale yellow and is often described as straw-colored. It is clear, normally containing no sediment, mucus strands or blood. The usual amount voided is 200 to 300 cc's on an average of five to six times a day for a total of 1,000 to 1,500 cc's every 24 hours. Urine normally has a slight ammonia odor, and certain foods or beverages may make the ammonia odor much stronger. The frequency of voiding will depend on a client's fluid intake, but most people void at least every three to four hours. Abnormal characteristics of urine include variations in color, cloudy urine, the presence of a great deal of sediment and amounts voided that are much lower or much higher than the amounts stated.

Maintaining Urine Elimination

The body needs an adequate intake of fluids for proper functioning of the urinary system. Water transports waste products in the body. Fluids must be taken in either orally or intravenously to serve as a method of transport for waste. If fluid intake is not adequate, the urinary system cannot transport waste out of the body. An adequate intake of fluids is 2,000 to 3,000 cc's in a 24-hour period. In long-term or acute care, most of the fluid is given between 7:00 a.m. and 7:00 p.m. to keep a client from having to get up during the night to void.

Most people have a pattern of voiding. For some people, the pattern of voiding will correspond to work breaks. Others may have established a pattern of voiding before each meal and at bedtime. Clients who have chronic health problems or poor mobility may be in the habit of using a bedside commode to void. Male clients may prefer to use a portable urinal. The nurse assistant can promote voiding by finding out the client's normal pattern of voiding. Urine elimination is promoted when the usual patterns or habits of voiding are followed as closely as possible. Many clients have "bashful bladders"; they are too embarrassed to void when other people are in the room. To promote adequate elimination, the nurse assistant should provide privacy when a client is voiding if safety can be maintained when the client is left alone.

Conditions That May Cause Abnormal Urine Elimination

Incontinence is the inability to stop or control the passage of urine. A client may experience one of several types of incontinence. Stress incontinence is the inability to control the passage of urine when pressure is placed on the bladder, such as by coughing, sneezing, laughing, exercising or pushing on the abdomen. Urge incontinence refers to the client's inability to retain the urine long enough to get to a bathroom. A client experiences involuntary urine passage soon after he or she senses a strong urgency to void. A client with a bladder infection may also experience urge incontinence. Clients who are elderly may have lost elasticity in the bladder and have weak sphincter muscles, causing urge incontinence. Neurogenic incontinence results when an injury or disease condition (originating in the nervous system) interrupts the pathways of sensation, leaving a client with the inability to sense the urge to void. Functional incontinence is caused by disease conditions or disabilities that create strong urges or bladder contractions that a client cannot control long enough to reach a bathroom or an appropriate receptacle. Medications may also cause incontinence. If a client does not get enough fluids, the urine becomes concentrated. It irritates the bladder and may cause the bladder to contract unexpectedly, causing incontinence. When a catheter has been in place for some time, the client may experience dribbling, or incontinence of small amounts of urine, when the catheter is removed. Dribbling occurs because the catheter has held the sphincters open and they need some time to regain their ability to be held tightly contracted until the client's conscious thought causes them to open and release urine.

Cystitis is an infection of the bladder. Cystitis is a fairly common condition. It occurs more frequently in women than men due to the shorter length of the female urethra. Signs that may be observed are frequent urination; **hematuria**, or blood in the urine; burning when urinating; and pain. The nurse assistant should monitor and report any signs of infection. A client should be encouraged to drink plenty of fluids, especially water and juices, and to refrain from drinking carbonated beverages and beverages with a high caffeine content, such as coffee and tea, which can cause ladder irritation and make an infection more likely. A client should urinate frequently rather than hold the urine, as the urine itself becomes a perfect environment for bacteria to grow. The perineal area should be kept clean with proper wiping from front to back after urinating and defecating.

Nephritis is the technical term for an inflammation of the kidney, which is usually caused by an infection. The symptoms are very similar to those of a bladder infection, with the addition of an elevated temperature, pulse, and blood pressure. The nurse assistant should follow the same procedures as for a bladder infection plus frequent checking of vital signs. Intake and output should be monitored so a determination can be made about whether kidney function is adequate.

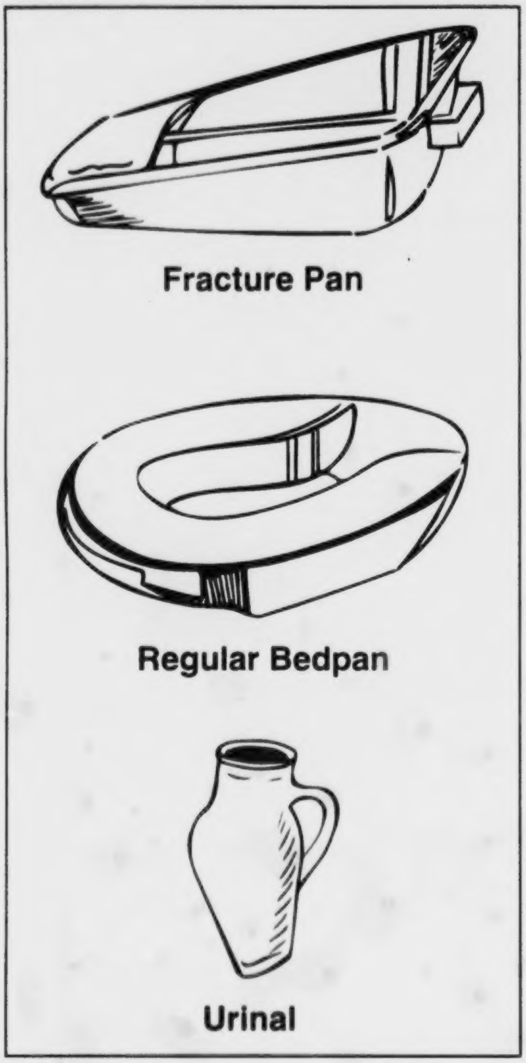
Renal calculi, or kidney stones, may block part of the urinary system. The most common symptom is pain that is unrelieved except by the strongest prescription pain medications. If the stones damage the urinary passageways, a client may have hematuria. A client will require regular pain medication, and fluids should be offered frequently to create a large amount of urine to help move stones along the urinary tract. Urine must be strained through a paper filter before it is disposed of to learn whether a client has passed the stones. If a client is unable to pass the stones, lithotripsy may be done. **Lithotripsy** is the use of high frequency sound waves directed toward the area where the stone is lodged in the kidney. The sound waves cause stones to break into tiny particles, which a client can then easily pass.

Urinary retention is a condition in which an individual experiences an inability to empty the bladder completely. It can be caused by poor bladder muscle tone, obstruction of the urethra or damage to the sensory pathways that stimulate contraction of the bladder. A client will complain of difficulty passing urine and a feeling of fullness in the lower abdomen and may urinate frequently in very small amounts. Triggering mechanisms may help a client relax, allowing the sphincter to open and the bladder to contract and release urine. Mechanisms to encourage voiding include having the client listen to the sound of running water, placing the client's hands in warm water, pouring water over the perineal area and gently pressing on the lower abdomen. If these triggering mechanisms do not work, the supervisor should be notified. A physician may order that a catheterization be done on the client.

General Considerations in Giving and Removing a Bedpan and Urinal

If a client cannot get out of bed to use a bedside commode or ambulate to the toilet, a bedpan or urinal must be used. A **bedpan** is a metal or plastic container that is used to collect feces and urine of a client unable to leave his or her bed. There are two types of bedpans, regular and fracture. The fracture bedpan is used for thin or disabled clients who do not have large stools or clients with medical conditions that prevent them from using a regular bedpan. A **urinal** is a metal or plastic container that holds urine; it is used by a male client. All three are illustrated in Figure 2.1. Privacy should be provided for clients before bedpans or urinals are used. Closing the door to a client's room, in addition to pulling the curtains around a client, provides a greater degree of privacy. When a client urinates in a container, the nurse assistant should observe the urine for abnormal characteristics before it is emptied. The

Figure 2.1 - Bedpans and Urinal



containers should be kept clean by rinsing them after each use. In long-term care, bedpans and urinals are disinfected once a week.

A urinal should be covered when not in use and when it is being carried to the toilet for emptying. As with a bedpan, a urinal should not be placed on an overbed table or bedside stand. Most urinals have a handle and may be hung over the bed rail for easy access by a client. Some men have difficulty urinating while in a supine position. If a client can stand, he may stand at the bedside to use a urinal or may be assisted to a sitting position on the side of the bed.

Steps of Procedure for Assisting Client with Urinal

1. Wash hands.
2. Put on gloves.
3. Assemble necessary equipment.
4. Identify and greet client.
5. Identify self.
6. Explain what you are going to do.
7. Provide privacy.
8. Turn back top bedding, except top sheet (to provide privacy).
9. Adjust client's clothing to expose perineal area.
10. Place client's penis in urinal and lay urinal between his legs.
11. Make sure urinal is placed at an angle to keep urine from spilling out; flat edge should be lying on bed.
12. Remove and appropriately dispose of gloves.
13. Wash hands.
14. Place call device within reach and leave room.
15. Return to room promptly when client calls.
16. Wash hands.
17. Put on gloves.
18. Remove and cover urinal. Take it to bathroom.
19. Measure urine if client is on intake and output and empty urine into toilet.
20. Clean equipment.
21. Remove and appropriately dispose of gloves.
22. Wash hands.
23. Store equipment.
24. Give client clean, wet washcloth to wash hands.
25. Place soiled washcloth in appropriate container.
26. Wash hands.
27. Make client comfortable.

28. Place call device within reach, if appropriate.
29. Record pertinent observations and report unusual occurrences to supervisor.

Since bedpans are made out of either plastic or metal, they may feel cold when they touch the skin. A bedpan can be warmed before being placed under a client by running warm water in it and over the rim. Sprinkling powder around the rim of a bedpan will decrease the friction on a client's skin and keep the bedpan from sticking to the client. A bedpan is easier to use with the head of the bed elevated, if the client's orders permit this. When a bedpan has been used, it should be covered with a paper towel as it is carried to a toilet for disposal. The bedpan should be emptied in the toilet or in a special waste-disposal unit; urine should NEVER be poured into a sink. The bedpan should be placed on the bed next to the client if the nurse assistant must reposition him or her after the use of the bedpan; it should not be placed on the floor, overbed table or bedside stand. If a bedpan is placed on the floor, it will pick up germs that rinsing may not remove. Placing a bedpan on an overbed or bedside table transmits the germs present on the bedpan to an area where food or personal articles may be placed.

Steps of Procedure for Assisting Client with Bedpan

1. Wash hands.
2. Put on gloves.
3. Assemble necessary equipment.
4. Identify and greet client.
5. Identify self.
6. Explain what you are going to do.
7. Provide privacy.
8. Place client in supine position or as close to supine position as possible.
9. Turn back top bedding, except top sheet (to provide privacy).
10. If client is able to assist
    a. Have client flex knees and lift buttocks off mattress. Assist by slipping hand under lower part of back. Adjust client's clothing to expose perineal area.
    b. With other hand, slip bedpan under client's hips and adjust it appropriately.

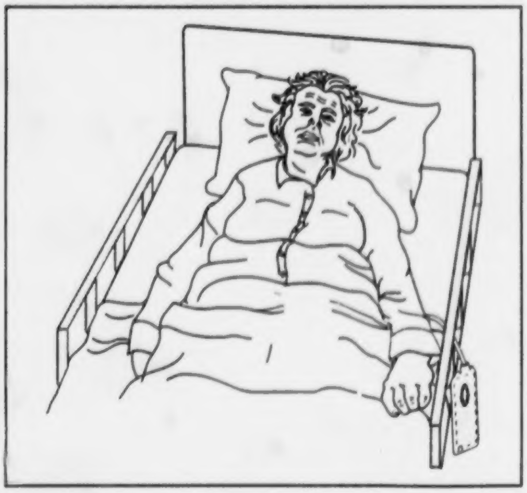
    If client is unable to assist
    a. Turn client on side, facing away from you.
    b. Expose client's buttocks and position bedpan firmly against buttocks.
    c. Place small pillow or rolled towel at top of bedpan at small of client's back.
    d. Turn client toward you and onto bedpan.
11. Raise head of bed (if allowed) and side rails for client's comfort and safety.
12. Place toilet tissue and call device within reach.
13. Remove and appropriately dispose of gloves.
14. Wash hands and leave room.
15. Return to room promptly when client calls, or check after five minutes. NOTE: DO NOT leave client on bedpan for more than ten minutes; doing so may lead to extreme discomfort and result in skin breakdown.
16. Wash hands.
17. Put on gloves.
18. Lower head of bed and side rail next to you.
19. If client is able to assist - Place one hand under small of client's back and assist client in raising hips. Hold bedpan with other hand.
    If client is unable to assist - Hold bedpan with one hand to prevent contents of bedpan from spilling, and roll client off bedpan with other hand.
20. Remove bedpan and cover it.

21. Wipe, wash and dry perineal area from front to back.
22. Take bedpan to bathroom; measure urine if client is on intake and output, and empty into toilet.
23. Clean equipment.
24. Remove and appropriately dispose of gloves.
25. Wash hands.
26. Store equipment.
27. Give client clean, wet washcloth to wash hands.
28. Place soiled washcloth in appropriate container.
29. Wash hands.
30. Make client comfortable.
31. Place call device within reach, if appropriate.
32. Record pertinent observations and report unusual occurrences to supervisor.

Managing Urinary Drainage

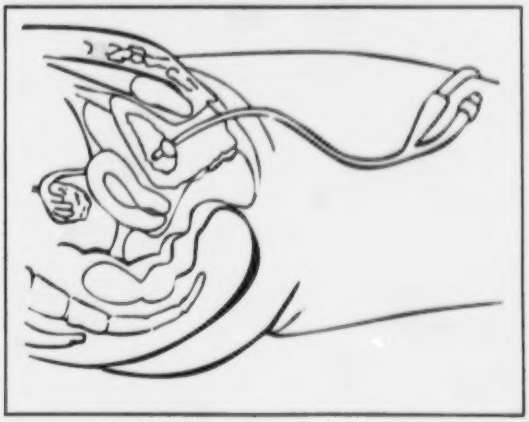
When a client cannot urinate, a urinary drainage system can be used. A **catheter**, which is a tube that drains urine from the bladder, is connected to a drainage bag (see Figure 2.2). A physician must order a catheter. Insertion of a catheter is a sterile procedure done by the nurse or a physician. A **straight catheter**, or **French catheter**, is a soft rubber or plastic tube that does not remain in the bladder but is used to drain the bladder once. In home health care, family members are sometimes taught straight catheterization. An **indwelling catheter**, or **Foley catheter**, has a balloon at the tip of the plastic tube; the balloon is blown up after insertion into the bladder to hold the catheter in place for a time. (See Figure 2.3.)

Figure 2.2 - Urinary Drainage Bag



Once inserted, the Foley catheter becomes a continuous closed drainage system that should not be taken apart unless the drainage bag and tubing need to be changed. Urine drains by gravity, so the tubing should always be free of kinks and the nurse assistant should check to see that the client is not lying on any part of the tubing. Urine will drain more freely if the tubing is coiled on the bed rather than hanging below the level of the drainage bag. The drainage bag should remain below the level of the bladder because urine will flow backward from the bag into the bladder if it is elevated above the body. The drainage bag should not drag on the floor but should instead be hung on the bed frame or chair. The nurse assistant should be careful not to pull catheter tubing when assisting a client with

Figure 2.3 - Indwelling Catheter

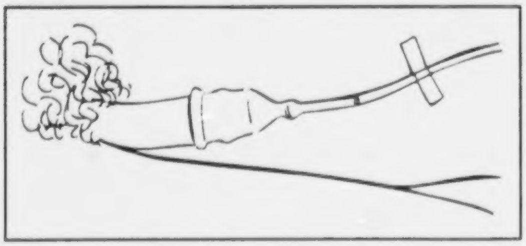


personal hygiene or other procedures.

Drainage into a catheter bag and tubing should be monitored throughout the shift to determine if a client's output is adequate and if his or her urine is displaying normal characteristics. The drainage bag is emptied as needed. A client with a urinary drainage system may be monitored for intake and output, so the amount emptied from the bag should be recorded. The nurse assistant should take care when emptying a bag so that the tip of the outlet tube does not touch the floor or other objects. A drainage bag can be changed as needed or as directed by the supervising nurse. The urinary meatus must be kept clean and free of secretions. The presence of a catheter sometimes stimulates the production of mucous at the urinary opening. Catheter care requires washing the area around the urinary meatus once per shift and after any bowel movement. (For a review of this procedure, see Unit 5, Lesson 9.)

A male client may have an **external catheter**, also called a **Texas™ catheter** or **condom drainage**, in which a condom-type sheath is fitted over the penis and attached to a tubing system and drainage bag. See Figure 2.4. The condom sheath may be attached in several ways, depending on the type of system used. The package will provide directions that should be followed to achieve a leak-free system. This procedure is not a sterile, internal procedure and may be done by the nurse assistant using clean technique. A client with an external catheter will require daily perineal care. The penis should be checked frequently for signs of irritation and restriction of circulation.

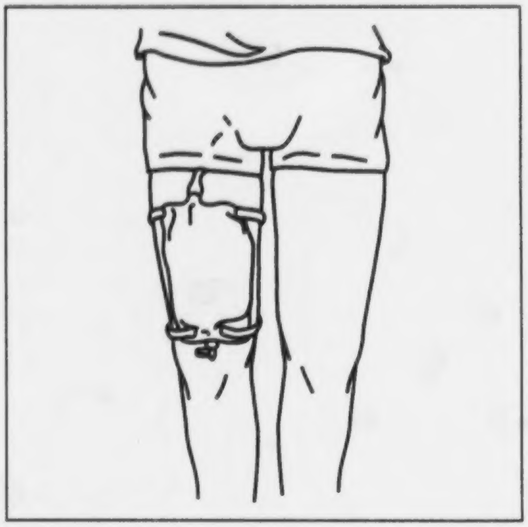
Figure 2.4 - External Catheter



Clients with catheters who are more mobile may use leg bags. Instead of the full drainage system, the tubing is connected to a **leg bag**, a smaller bag that can be strapped to the thigh or lower leg, as shown in Figure 2.5. The bag and tubing system can then be hidden under the client's clothing. The bag must be emptied more frequently as it is smaller than the regular drainage bag. A leg bag may be used during the day, with the client reconnected to a larger drainage bag each night. If the leg bag is used intermittently, it should be rinsed well after each use. A weak vinegar solution can be used to rinse the bag to assist in reducing odors and preventing the growth of bacteria.

Home health care clients may require intermittent catheterization to manage urinary retention. If a client is unable to do the procedure, the supervising nurse

Figure 2.5 - Catheter with Leg Bag



may train a caregiver in the home to perform this procedure. If the caregiver requests that the home health aide perform the procedure, the home health aide should indicate that special training is required and the request should be declined. The request should be reported to the supervisor.

Steps of Procedure for Changing a Drainage Bag

1. Wash hands.
2. Put on gloves.
3. Assemble necessary equipment.
4. Identify and greet client.
5. Identify self.
6. Explain what you are going to do.
7. Provide privacy.
8. If applying reusable leg bag, swab end to be connected to catheter tubing with alcohol and place on sterile gauze in alcohol packet. Do not allow it to touch anything else.
9. Crimp catheter tubing with fingers or clamp so urine does not flow.
10. Disconnect catheter tubing from drainage bag. If drainage bag is to be reused, apply cap over end of tubing.
11. Connect bag to catheter.
12. Unclamp catheter tubing.
13. Check to see that urine is flowing; it may take a few minutes.
14. If placing leg bag or applying new tape, allow enough slack so that bag does not pull on catheter.
15. If drainage bag is to be reapplied later, remove cap, swab end with alcohol, and replace cap.
16. Remove and clean equipment.
17. Remove and appropriately dispose of gloves.
18. Wash hands.
19. Store equipment.
20. Make client comfortable.
21. Place call device within reach, if appropriate.
22. Record pertinent observations and report unusual occurrences to supervisor.

Bladder Training

Bladder training is actually *retraining* the bladder as a therapy for incontinence; it is the procedure of placing a client on the toilet, commode or bedpan at specific times throughout the day and night so that the bladder becomes accustomed, or trained, to emptying at those intervals. Before beginning the training, the nurse assistant should observe a client's voiding intervals. For example, if the client involuntarily voids every two hours, then bladder training will be based on the assumption that the client's bladder cannot hold more urine than is produced in that time. The client will then be toileted every two hours during the day and night. However, since body systems are at rest during the night (assuming the client sleeps), not as much urine is produced, and the client may not need toileting as frequently at night.

Fluids must be provided to keep urine diluted. A schedule should be set up to offer the client fluids at intervals during the day. A schedule is kept of the times fluids are given and the times at which the client is to be toileted. A sample schedule is shown in Figure 2.6. Even with a schedule for fluid intake and routine toileting, a client may have an occasional accident, which should be dealt with calmly and with understanding. Adjusting the schedule so that toileting is done more frequently may then be necessary.

Bladder training can be started while a client has a catheter by clamping the catheter shut and opening it at specific times. This practice strengthens the bladder muscles to hold a quantity of urine. When the catheter is removed, the

Figure 2.6 - Sample Bladder Training Schedule

Time	**Resident voided Y or N**	**Resident had some leaking LA=large amt. SA=small amt.**	**Dry Y or N**	**Amount Voided (cc)**	**Intake of fluids (cc and type)**
12-1 am					
1-2 am					
2-3 am					
3-4 am					
4-5 am					
5-6 am					
6-7 am					
7-8 am					
8-9 am					
9-10 am					
10-11 am					
11 am-12 pm					
12-1 pm					
1-2 pm					
2-3 pm					
3-4 pm					
4-5 pm					
5-6 pm					
6-7 pm					
7-8 pm					
8-9 pm					
9-10 pm					
10-11 pm					
11 pm-12 am					

toileting schedule is maintained to correspond to the times when the catheter was released.

Incontinent briefs are either paper or cloth products made in an adult size and padded to absorb urine. They may be needed for incontinent clients who do not respond to bladder training. Incontinent briefs should be checked frequently and changed as soon as they are wet or soiled. Perineal care should be given before a clean incontinent brief is applied and the skin observed for any signs of breakdown. Briefs should not be referred to as diapers, as this shows a lack of respect for a client. The application of an incontinent brief is never to be used as a substitute for toileting a client.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 2: Urinary Elimination

Activity Sheet

1. Describe the normal characteristics of urine.

2. How much fluid must the body take in over a 24-hour period to maintain urinary elimination?

3. What are the five types of incontinence? Describe each type.

    a.

    b.

    c.

    d.

    e.

4. Describe the following conditions.

    a. Cystitis

    b. Hematuria

    c. Nephritis

    d. Renal calculi

    e. Urinary retention

5. List two things that can be done to make a bedpan more comfortable for a client to use?

   a. ______________________________

   b. ______________________________

6. What is a catheter?

   ____

7. What is an external catheter?

   ____

8. Name the three types of catheters.

   a. ______________________________

   b. ______________________________

   c. ______________________________

9. What are six ways to maintain drainage from a Foley catheter?

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

   e. ______________________________

   f. ______________________________

10. What is meant by bladder training?

    ____

    ____

    ____

11. List two considerations that should be provided for clients wearing incontinent briefs?

    a. ______________________________

    b. ______________________________

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedures, practice the following in the laboratory: changing a drainage bag, assisting with a urinal and assisting with a bedpan.

2. Monitor your fluid intake and voiding for 24 hours. Work in groups of three to four to compare fluid intake. Who is below the recommended levels? Who is above the recommended levels of fluid intake?

Lesson 3:
Bowel Elimination

Objectives:

A. Describe characteristics of normal and abnormal stools.

B. Identify the factors that maintain normal bowel elimination.

C. Discuss abnormal bowel conditions.

D. Describe special measures that promote bowel functioning.

E. Discuss the general considerations in giving enemas.

F. Administer unmedicated enemas.

G. Describe bowel training.

Key Terms:

- Feces, stool or bowel movement
- Peristalsis
- Defecation
- Constipation
- Impaction
- Distended
- Diarrhea
- Hemorrhoids
- Bowel obstruction
- Bowel incontinence
- Laxatives
- Enema
- Bowel training
- Digital stimulation

Elimination of waste products is one of the body's basic functions. The bowels must function properly to eliminate solid waste. Disease processes, lack of mobility, or lack of proper substances in the diet can disrupt the bowel habits of clients. Some clients may be concerned about bowel dysfunction due to aging. Their complaints should not be ignored, and every effort should be made to encourage good bowel habits. The nurse assistant should monitor bowel elimination patterns and assist the client in maintaining bowel elimination to promote comfort and good health.

Characteristics of Normal and Abnormal Stool

The substance eliminated from the bowel is called **feces**, **stool** or a **bowel movement**. Normal stool is light to dark brown in color. The normal consistency is soft and formed. The frequency of bowel movements varies with each individual, but the general pattern is from once or twice a day to every third day. The stool will either be odorless or have the smell of decomposing food. Strong odors can be attributed to foods that produce sulfurous gas upon decomposition. If an infectious process is present in the bowel, the stool may have a variety of odors, from a slightly sweet to a highly odorous, rank smell. Stool that contains blood will have a slightly sweet odor. Abnormal stool may be green-tinged, yellow, gray or pasty white in color. Bright red streaks in the stool indicate bleeding. If the bleeding occurs high in the gastrointestinal tract, the stool will be very dark, almost black, in color and will be slightly sticky in consistency. Stool should not contain undigested food, blood or mucus. Stool should be neither very large or very small in diameter nor should it be either liquid or very hard.

Factors That Maintain Normal Bowel Elimination

A diet containing fiber helps to maintain normal bowel elimination by making a stool softer. Fiber holds water in the waste in the colon, making the stool less solid. Fibrous foods are also slightly irritating to the bowel, causing the bowel to contract and consequently causing waste to move along more rapidly. The nurse assistant should encourage foods such as fresh fruits, fresh vegetables, prunes and bran cereal in the diet since these contain the greatest amount of fiber.

Fluids make stools softer. If stool is soft, moving it along the bowel as it contracts is easier. The nurse assistant should encourage the client to drink 3,000 cc's of fluids every twenty-four hours. Juices, such as orange, apricot and prune, are particularly helpful because they provide not only fluid but a small amount of fiber. The client may need to be placed on intake and output to determine if he or she is taking in sufficient fluids to maintain bowel elimination.

Physical activity stimulates the bowel to contract and move waste due to the pushing of the abdominal muscles against the intestines. The more the abdominal muscles contract, the more the bowel is stimulated to produce **peristalsis**, the progressive wave of contractions occurring within the bowel. Because of this effect, the nurse assistant should encourage clients to ambulate. If ambulation is not possible, clients can be encouraged to participate in activities of daily living. If a client is unable to participate in the activities of daily living, range of motion exercises should be done and a client's position should be changed every two hours.

The bowel develops a routine of eliminating waste at a certain time of day. The time of usual **defecation**, the elimination of stool, may be after eating a meal or drinking certain fluids, as peristalsis occurs at this time. Bowel elimination can be maintained if a client is toileted when defecation usually occurs. The nurse assistant should determine when a client usually defecates. Either the client or the family can be questioned about the client's bowel habits, including frequency, time of day and assistance measures needed, such as suppositories, enemas or medications. When a routine time has been determined, the nurse assistant should provide privacy and allow time for the bowel to evacuate. If possible, clients should be placed in a sitting position to allow the full use of abdominal muscles to increase pressure in the abdomen and to aid in the passage of stool. A client may be more comfortable on a bedside commode than using a bedpan as the "normal" sitting position used on a commode may help in having a bowel movement.

Abnormal Bowel Conditions

Constipation, the passage of unusually dry, hard stools, is the most frequently encountered abnormal bowel condition. The elderly in particular have a problem with constipation as peristalsis slows with aging. Clients in a health care facility may have had their normal bowel habits interrupted, causing a potential for constipation. Four factors usually cause constipation: lack of fluid, lack of fiber, lack of activity and lack of privacy that can affect the ability to defecate at a usual time. Medications can also cause constipation as can depression, a feeling of sadness and despair that causes the entire body to slow down. Aging of the digestive tract may also result in poor peristatsis.

An **impaction** is a hard mass of stool that forms in the bowel and cannot be passed normally. An impaction can form anywhere along the large intestine, but the most frequent location is in the rectum where stool loses water back to the body and can become too hard to pass normally. Liquid stool from above the impaction may seep around the hard mass and leak from the rectum. A client may complain of pain or a feeling of fullness in the rectum or abdomen. The abdomen may look **distended**, more rounded and fuller than usual.

Diarrhea is the frequent passage of liquid stool. Diarrhea may be from a semi-solid consistency to nothing more than colored water. The frequency of the stools, as well as the color, consistency and amount, should be noted. The liquid stool may need to be measured and recorded as output. A client experiencing diarrhea should be encouraged to take oral fluids unless he or she is also vomiting. Clear liquids such as water, clear carbonated soda and broth are preferred as these are less irritating to the gastrointestinal tract. The perineal area can become very irritated due to the constant passage of stool and should be kept clean and dry.

Hemorrhoids are varicose veins in the rectum. They may be either internal, which cannot be seen, or external, which protrude from the rectum. They are very tender and may bleed. Straining when passing stool and prolonged toilet sitting can cause hemorrhoids. Pregnancy or heavy lifting may also cause them. A client may complain of pain in the rectal or anal area, or itching at the anus. If the hemorrhoids bleed, it will be seen as streaks on the outside of the stool, staining of the toilet water or a smear on the toilet paper. A client may be reluctant to defecate because of the pain and as a result become constipated.

A **bowel obstruction** is a blockage in the bowel, either partial or complete, causing difficulty for a stool to pass through the area of blockage. Many things can cause a blockage: impacted stool, a tumor or a twisted bowel. A client will complain of abdominal pain and the abdomen will be distended. No stool will pass for several days. If the obstruction is not relieved, the client may begin to vomit fecal material as the bowel fills with waste products. Since an obstruction is an acute problem, any signs should be reported immediately to the supervisor.

Bowel incontinence is the inability to stop or control the passage of stool. If the sphincter muscle is weak, a client may not be able to hold fecal material until he or she can get to a bathroom. Those clients who are confused may not recognize the need to defecate and may be unaware of when stool is being passed. Any condition that damages the sensory pathways to the rectum may cause a client to be unaware of the need to defecate. Bowel incontinence should never result because a client has limited mobility and assistance is not provided in time to help with toileting needs.

Special Measures to Promote Bowel Functioning

The nurse assistant should promote the four factors that encourage proper bowel functioning; adequate fluid intake, fiber intake, activity and privacy for defecation. Any of the special measures to promote bowel functioning presented below must be ordered by a physician.

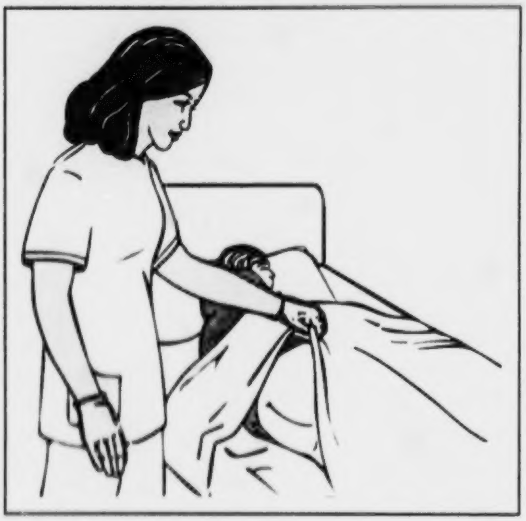
Laxatives are medications that promote peristalsis by irritating the colon, providing bulk in the stool, or increasing the fluid content of the stool. They may be taken by mouth or in a rectal suppository form. A licensed nurse or medication technician must administer laxatives.

An **enema** is an infusion of fluid into the rectum to stimulate defecation. An enema may be used for reasons other than the relief of constipation. It may be given prior to x-rays or other diagnostic exams to clear the bowel of stool so structures can be clearly visualized, before surgery to clear the bowel to prevent accidental soiling during anesthesia, and as a stimulant for defecation during a bowel training program. Many types of enemas are used, some containing medication. The nurse assistant is generally not responsible for the preparation or administration of enemas containing medication. The types of enemas that the nurse assistant can administer are the soap suds enema (SSE), a solution of tap water and a mild liquid detergent soap; the saline enema, a solution of tap water and salt; and the tap water enema (TWE), an enema of plain tap water. The amount of fluid usually designated for these types of enemas is 500 to 1,000 cc's. The home health aid may order commercially prepared enemas for clients that are available for purchase at a local drugstore. The solution is ready to administer in a prepackaged container with a lubricated tip. The home health aide should check with his or her facility or agency to determine if policies allow for the aide to administer this type of enema.

General Considerations in Giving Enemas

The best position to place a client in to receive an enema is the Sims' position, a left lateral position illustrated in Figure 3.1. The client lies on his or her left side with the right leg drawn up toward the chest. The client may feel more comfortable "hugging" a pillow held along the trunk of the body. If the client cannot lie on his or her left side, the enema can be given with the client in a supine position with the knees flexed and separated. If the client is not going to be able to hold the fluid, a bedpan can be put in place.

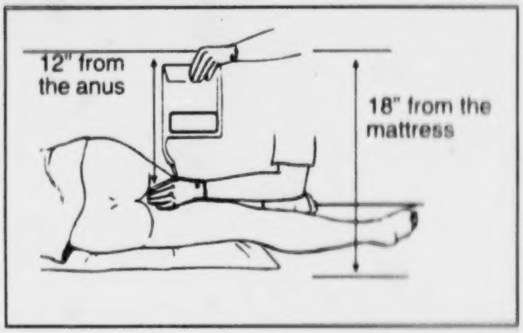
Figure 3.1 - Sim's Position



The bathroom should be checked for availability before the enema is administered, and the path to the bathroom should be cleared so that the client has immediate access when the fluid has been administered. If possible, the enema should be given before the client's bath. Immediately before or immediately after a meal is not a good time for the administration of an enema as the procedure may cause abdominal cramping. In addition, the smell associated with the fecal material may make some clients slightly nauseated. The procedure can also exhaust elderly clients so that they do not feel like eating after receiving an enema with a water-soluble lubricant.

Enema tubing should be well lubricated with a water-soluble lubricant to reduce friction during insertion into the anus. If a client takes a deep breath while the tubing is inserted, the sphincter relaxes so insertion is easier. The container holding

Figure 3.2 - Proper Height of Enema Solution Container



the enema solution should never be held higher than twelve inches above the anus, as shown in Figure 3.2. If the client complains of cramping during the administration of an enema, the solution may be flowing in too rapidly. The container holding the solution can be lowered to see if this relieves the cramping. Breathing deeply through his or her mouth during the procedure may help a client to relax. If a client has difficulty holding the solution, the flow of solution can be stopped for a few minutes, leaving the tubing in place, and then started again when the client has regained sphincter control. If a client has severe cramps or pain that does not go away, starts perspiring heavily or feels faint, the enema should be stopped and the supervisor notified. If a client is taken to the bathroom to pass the enema solution and stool, the toilet should not be flushed until the results of the enema are checked.

Steps of Procedure to Administer an Unmedicated Enema

1. Wash hands.
2. Put on gloves.
3. Assemble necessary equipment.
4. Identify and greet client.
5. Identify self.
6. Explain what you are going to do.
7. Provide privacy.
8. Have client empty his or her bladder; assist with bedpan or bedside commode.
9. Client should be in bed, with head of bed flat if possible; cover client with bath blanket and turn down top bedding.
10. Place bed protector under buttocks.
11. Assist client to turn or turn client to left side with knees flexed, if possible.
12. Place bedpan at foot of bed or bedside commode near bed if client cannot go to bathroom.
13. Clamp enema tubing; fill enema bag with amount of solution ordered by physician.
14. Expel air from tubing by allowing a small amount of solution to flow into bedpan or bedside commode, then clamp or pinch tubing a few inches from tip.
15. Put about a teaspoon of lubricant on piece of toilet paper. Rub lubricant on lower three inches of tube.
16. Raise upper buttock to expose anus.
17. Ask client to take a deep breath while you insert tip of rectal tube. Rotate tip slowly as you insert it about three inches. If you feel resistance or if client complains of pain, remove tube, cover client and notify supervisor.
18. Release lifted buttock and unclamp tubing. Hold bag or place it so that level of solution is never higher than 12 inches above anus.
19. Adjust flow of solution for client's comfort; lower bag if client complains of cramping.
20. Have client take deep breaths through mouth to relax him or her during flow of solution.
21. If client has severe cramps or pain that does not pass, starts perspiring heavily or feels faint, discontinue enema and notify the supervisor.

22. If client has trouble holding solution, stop flow for a few minutes and then start again.
23. Clamp tube when solution is taken and remove tube, rotating it slowly and gently as you pull it out. Wrap tube in paper towel.
24. Ask client to retain solution as long as possible. You can assist by applying slight pressure over anal region by holding or pressing buttocks together.
25. Assist client onto bedpan or bedside commode, or assist to toilet. If client is taken to bathroom, instruct client not to flush toilet so results can be checked.
26. Place call device and toilet tissue within reach.
27. Remove and appropriately dispose of gloves.
28. Wash hands.
29. Leave room unless assistance is needed.
30. Check on client after five minutes or when client calls.
31. Wash hands.
32. Put on gloves.
33. When client is finished, remove bedpan or bedside commode and observe results, noting characteristics of stool.
34. Clean perineal area with wet washcloth and dry thoroughly.
35. Give client a clean, wet washcloth to wash hands.
36. Place soiled washcloths in appropriate container.
37. Remove, clean and store equipment.
38. Remove and appropriately dispose of gloves.
39. Wash hands.
40. Make client comfortable.
41. Place call device within reach, if appropriate.
42. Record pertinent observations and report unusual occurrences to supervisor.

Bowel Training

Bowel training is a program that is set up to assist a client in eliminating stool at a set time of day. The training program helps to establish a regular schedule of elimination so bowel incontinence does not occur. Before beginning bowel training, a client is observed to determine if a pattern of bowel movements exists. If a pattern is observed, bowel training is set up to follow this pattern of elimination. For example, if a client is incontinent of stool every other day after breakfast, then the bowel training program would be set up following a routine based on toileting every other day after breakfast.

For some clients, placing them on a bedpan, commode or toilet at these predetermined times is enough to keep them continent of stool. For other clients, the physician may need to order special measures to promote bowel elimination. Bowel training may be started by administering enemas at established times every day or every other day. Once the bowel has gotten into a routine of being stimulated at the same time every day, the physician may be able to substitute a suppository for the enema. Administering the suppository and performing **digital stimulation**, the massage of the internal anal canal with a gloved, lubricated finger, keeps up the routine of eliminating stool at a prescribed time. Digital stimulation causes the colon to contract and promotes the passage of stool. After a period, a suppository may no longer need to be given and digital stimulation alone will be enough to cause the colon to evacuate. Bowel training requires patience as the bowel does not develop a routine overnight. Clients must be made aware that accidents can still occur if intestinal illness develops causing diarrhea or if something is eaten that upsets the bowel.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 3: Bowel Elimination

Activity Sheet

1. Describe the characteristics of normal stool.

____

____

____

2. Describe four characteristics of abnormal stool.

a. ______________________________

b. ______________________________

c. ______________________________

d. ______________________________

3. Identify the four factors that maintain normal bowel elimination.

a. ______________________________

b. ______________________________

c. ______________________________

d. ______________________________

4. Describe the following:

a. Constipation ______________________________

b. Impaction ______________________________

c. Diarrhea ______________________________

d. Hemorrhoids ______________________________

e. Bowel obstruction ______________________________

f. Bowel incontinence ______________________________

5. What are laxatives?

6. What is an enema?

7. Describe the following types of enemas.

   a. Soap suds enema (SSE) __________

   b. Saline enema __________

   c. Tap water enema (TWE) __________

8. What is the preferred position for a client to receive an enema? What is the alternate position?

   a. __________

   b. __________

9. What can the client be instructed to do to make the enema procedure more tolerable?

10. What should you do if the client complains of cramping during the administration of an enema?

11. Under what conditions should the enema procedure be stopped and the supervisor notified?

12. What is bowel training?

13. What is digital stimulation?

____

____

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedure for administering an enema, practice the procedure on a model in the laboratory.
2. Practice making the different types of enema solutions in the laboratory.
3. Interview two people to find out what practices they use to keep their bowels regular. Work in groups of three or four to compile your information. Present your group's findings to the class.

Lesson 4:
Ostomies

Objectives:

A. Differentiate between types of ostomies.

B. Identify the general principles of ostomy care.

C. Change an ostomy bag.

Key Terms:

- Ostomy
- Stoma
- Colostomy
- Ileostomy
- Ureterostomy
- Ileal conduit
- Appliance
- Irrigation

An **ostomy** is a surgically-made opening through the abdominal wall to one of the body's organs. They may allow products either to leave or enter the gastrointestinal tract, or to leave the urinary tract. The opening made on the outside of the body is called a **stoma**. A gastrostomy, a surgical opening made into the stomach for administering liquid feeding, has already been discussed in the unit on nutrition. This lesson will focus on the ostomies made for eliminating waste from either the gastrointestinal tract or the urinary tract.

Types of Ostomies

A **colostomy** is an opening into the colon on the abdominal wall. The colostomy can either be permanent, if part of the bowel is removed because it is diseased or injured, or temporary, giving the bowel a rest for a period before the colon is reconnected. Colostomies are named from the placement of the stoma. An ascending colostomy is on the right side of the body over the ascending colon. A transverse colostomy is somewhere across the midline of the body, slightly below the waist. A descending colostomy is on the left side of the body over the descending colon. A colostomy can be either a single barrel or double barrel. The single barrel colostomy has only one end of the bowel opening as a stoma on the abdomen. The double barrel colostomy has both ends of the bowel opening side by side as a stoma. A surgeon, knowing what is best for the disease or injury that the client has, decides which type of colostomy is made. An **ileostomy** is an opening into the ileum, which is part of the small intestine. The stool from an ileostomy will be much more liquid than from a colostomy since the bowel has not reabsorbed water from the stool. These types of ostomies are for the elimination of feces from the bowel.

A **ureterostomy** is a new opening on the abdomen for the ureter. The bladder is removed as a reservoir for urine and the urine drains directly from the kidney to the outside of the body. The client may have bilateral ureterostomies, meaning that ureters on both sides of the body have openings on the abdomen or flank. If the ureters are long enough, they may be brought together and exit the body in one stoma. Another procedure that the surgeon can perform to manage urinary drainage is the **ileal conduit**, in which a section of the bowel is removed and sewn together to make a small pouch. The ureters are placed into this newly created pouch and one end of this bowel pouch is brought to the surface of the abdomen and sewn there as a stoma. These types of ostomies are for the elimination of urine from the kidneys.

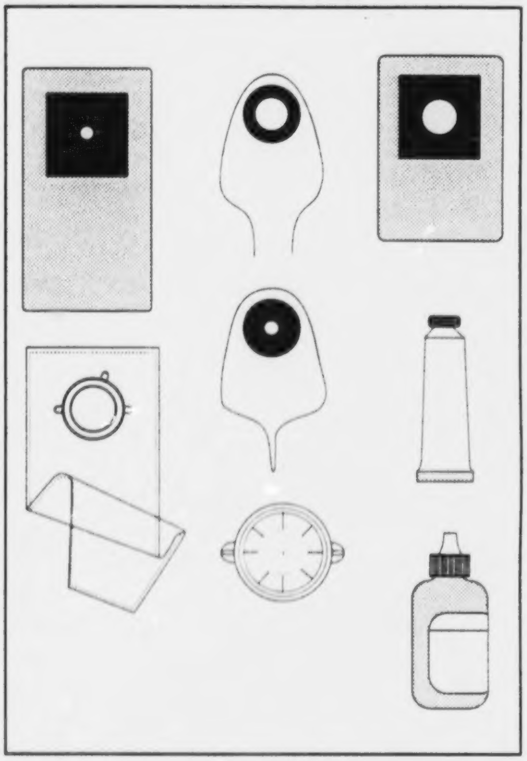
General Principles of Ostomy Care

The creation of a new opening on a client's body is a drastic change in body image. The client can no longer eliminate urine or stool in the "normal" way and now has a prominent red, raised opening on his or her body. The surgery to create the ostomy and the adjustment to a different elimination pattern has a great emotional impact on a client. The nurse assistant should be supportive of a client as he or she attempts to cope with this change. The client may demonstrate some of the coping behaviors discussed in Unit 3, Lesson 2. The client will be very conscious of odors and may think that others will know that he or she has an ostomy. The client with a new ostomy will need a great deal of patience, understanding and reassurance as he or she attempts to learn how to manage it independently.

The nurse assistant should observe the stoma daily for any abnormalities. A normal stoma will be pink to light red in color and will be moist like the mucous membranes of the mouth. It will be raised slightly off the abdomen. The skin around the stoma should be smooth and free of irritation. Any abnormalities in color, moisture, height, or the surrounding skin should be reported to the supervisor.

A client must wear a bag to collect the urine or feces eliminated from the ostomy. The collection bag is usually called an **appliance** and is held in place over the stoma by a combination of methods: paste, adhesive, a plastic ring, and/or a belt. Some appliances are used only once and are disposed of when they are removed from the body. Other appliances are reusable and must be cleaned before being reapplied. Appliances may have many shapes as can be seen in Figure 4.1; some are closed, while others are open on the end and held closed with a clamp while being worn. Some have rubber rings or hard plastic rings to seal the device around the stoma. Others have a sticky pad around the opening that goes over the stoma. A client may have to try several types of appliances before finding one that works best for him or her.

Figure 4.1 - Ostomy Appliances



The collection bag must be emptied or changed at routine intervals. The interval will vary since each person produces urine or stool at a different rate. If the bag is allowed to fill to capacity, the weight of the urine or feces may break the seal around the stoma, leading to a leakage of the urine or stool. The bag should always be changed if the seal has been broken to stop or prevent leakage.

The skin around the stoma can be easily irritated due to contact with urine or stool, or from the constant removal and attachment of an appliance. The skin should be kept clean and dry and observed carefully for any signs of breakdown. A moisture protectant spray or skin barrier may sometimes be applied if there is danger of the skin breaking down.

Some clients may have to irrigate their colostomy. **Irrigation** is the introduction of a fluid into the stoma. The procedure is very similar to an enema and is given for the same purpose, to cause the bowel to evacuate its contents. The irrigation of a colostomy allows the bowel to eliminate in a regular pattern, very similar to bowel training. Thus, a client will not have to worry about feces filling up an appliance during the day since the bowel is trained to eliminate after irrigation.

Steps of Procedure for Changing an Ostomy Bag

1. Wash hands.
2. Assemble equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Fold bed linens to bottom of bed.
7. Cover client with bath blanket.
8. Place disposable bed protector under client's hips.
9. Place bedpan within easy reach.
10. Place basin, soap, washcloth and towel within easy reach.
11. Wash hands.
12. Put on gloves.
13. Expose ostomy and remove soiled ostomy bag. If disposable type, place in plastic waste bag. If reusable, place in bedpan.
14. If stoma has continual drainage (example; an ileostomy or ureterostomy), roll a 4x4 gauze pad and place into stoma to absorb drainage while changing appliance.
15. Wipe area around stoma with toilet tissue.
16. Dispose of tissue in plastic bag.
17. Cleanse around stoma with soap and water.
18. Dry thoroughly.
19. Apply clean ostomy appliance.
20. Remove disposable bed protector.
21. Remove equipment.
22. If reusable ostomy bag is used, take to bathroom and empty into toilet. Clean out reusable bag using soap and water. Place on paper towel in bathroom to dry.
23. Clean and store equipment.
24. Remove and appropriately dispose of gloves.
25. Wash hands.
26. Give client clean, wet washcloth to wash hands.
27. Place soiled washcloth in appropriate container.
28. Wash hands.
29. Make client comfortable.
30. Place call device within reach, if appropriate.
31. Record pertinent observations and report unusual occurrences to supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

After you have completed the activity sheets, you may take the written evaluation for this section of this unit. A score of at least 80 percent indicates that you may proceed to the next section of this unit. Check with your clinical supervising staff member for skill testing.

Lesson 4: Ostomies

Activity Sheet

1. What is an ostomy?

   ____

2. What is the difference between a colostomy and an ileostomy?

   a. Colostomy ______________________________

   b. Ileostomy ______________________________

3. What is the difference between a single barrel and a double barrel colostomy?

   a. Single barrel colostomy ______________________________

   b. Double barrel colostomy ______________________________

4. Where will the following colostomies be found?

   a. Ascending colostomy ______________________________

   ____

   b. Transverse colostomy ______________________________

   ____

   c. Descending colostomy ______________________________

   ____

5. What is the difference between a ureterostomy and an ileal conduit?

   a. Ureterostomy ______________________________

   b. Ileal Conduit ______________________________

   ____

   ____

   ____

6. What is the difference between a colostomy and a ureterostomy?

   a. Colostomy ____________________

   b. Ureterostomy ____________________

7. What should a normal stoma look like?

   ____

   ____

8. How does a client with an ostomy manage the drainage?

   ____

   ____

9. What does it mean if a client has to irrigate a colostomy?

   ____

   ____

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedure, practice changing an ostomy bag on a model in the laboratory.
2. Examine the different types of appliances that the client with an ostomy may wear.

Lesson 5:
Specimen Collection

Objectives:

A. Identify reasons why specimens may be ordered.

B. Identify general principles of specimen collection.

C. Identify frequently collected specimens.

D. Collect a midstream clean-catch urine specimen.

E. Collect a 24-hour urine specimen.

F. Collect a sterile urine specimen from a catheter.

G. Collect a stool specimen.

H. Collect a sputum specimen.

Key Terms:

- Asepsis
- Urinalysis
- Urine specimen
- Clean-catch
- Midstream
- 24-hour urine specimen
- Sterile urine specimen
- Stool specimen
- Occult blood
- Sputum
- Saliva

Specimen collection procedures are an important part of client care and are generally easy to do. The nurse assistant must remember that the accuracy with which specimens are collected will affect the results and consequently the course of treatment that a doctor prescribes for a client.

Reasons for Specimen Collection

The human body performs many functions. One of its functions is to get rid of the waste products produced by the organs and organ systems of the body. When the body is functioning as it should, no one takes notice of these wastes. However, when something goes wrong, a doctor may want to examine some of these waste products.

The body is in a continual process of building up and tearing down. By-products are a result of this process. These wastes, which include carbon dioxide and mucous secretions from the respiratory system, solid wastes from the digestive system and urine from the urinary system, often show changes when a client is ill. As a part of his or her examination, a doctor may request that certain waste products be sent to a laboratory for examination. The results of these tests will aid the doctor in diagnosing an illness and evaluating the effectiveness of any treatment used.

Principles of Specimen Collection

In health care settings, nurse assistants may be responsible for collecting specimens and sending them to a laboratory. For test results to be accurate, specimen collection must be done correctly. Some specimens may be collected at any time, while others will have time limitations. Labeling of the specimen must also follow specified guidelines. Any unlabeled specimen should be thrown away to avoid mistakes.

The nurse assistant must remember that **asepsis,** being free from microorganisms, is an important part of infection control. In order to maintain asepsis, the nurse assistant should always wash his or her hands thoroughly before and after collecting a specimen.

Nurse assistants must follow instructions exactly when obtaining a specimen for analysis. All health care workers must use protective equipment, including gloves and goggles. This equipment will help protect the worker from possible contamination and disease transmission when handling specimens. Along with proper hand washing, these precautionary measures are very important in preventing the spread of infection. Standard precautions should always be followed during procedures in which the nurse assistant may be splashed with body fluids.

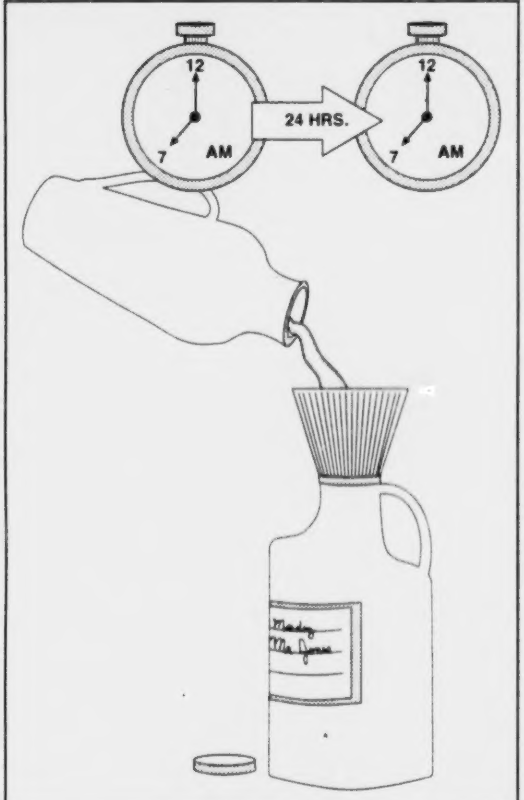
Any equipment used must be cleaned and returned to the proper storage area. The nurse assistant must be sure to close bottles, jars or tubes used with specimen collection to avoid spills, waste and accidents. The nurse assistant should always work in the proper area, whether it is a client's bathroom or a properly designated "dirty" room. All hazardous waste should be discarded in proper containers. When collecting specimens, the nurse assistant should always remember to follow the "Rights of Specimen Collecting."

- Right Patient - from whom the specimen is to be collected
- Right Specimen - as ordered by the doctor
- Right Time - when the specimen is to be collected
- Right Amount - correct measurement of the specimen
- Right Container - correct container for each specimen
- Right Label - properly filled out from the patient's identification bracelet
- Right Requisition - correct laboratory slip
- Right Method - the procedure in which the specimen is collected
- Right Asepsis - thorough and proper hand washing before and after collecting
- Right Attitude - how you approach and speak to the patient

Frequently Collected Specimens

Urine is one of the most frequently collected specimens. The urinary system excretes about 1 to 1.5 liters of urine daily. Urine consists of 95 percent water and 5 percent waste products from the breakdown of protein, pigments, toxins, hormones and any abnormal components found in the blood stream. A **urinalysis** is a series of tests determining the composition of urine. A urinalysis consists of checking the color, clarity, pH, specific gravity, odor, volume and any abnormal components. A **urine specimen**, which is a sample of urine taken from a client for laboratory evaluation, is routinely collected on admission to a hospital, before going into surgery, for sugar and acetone testing, etc. Urine specimens may be collected using a **clean-catch** technique, in which the specimen is not contaminated by anything outside of a client's body. **Midstream** collection technique involves collecting a specimen between the time a client begins to void and when he or she stops. Other types of urine specimens that may be collected are a 24-hour urine specimen and a sterile urine specimen. A **24-hour urine specimen**, illustrated in Figure 5.1, is a specimen collected over a 24-hour period. When collecting a 24-hour

Figure 5.1 - Collecting a 24-Hour Urine Specimen



specimen, the first urine specimen is thrown away, and all urine is collected for the next twenty-four hours until the same time the following day. For example, the client voids at 8:20 a.m. and this urine is discarded, all urine after that voiding is collected. The client is asked to void at 8:20 a.m. the next day and this urine is kept. Generally, the collection process begins in the morning. A **sterile urine specimen** is obtained from a closed drainage system (such as a catheter) using sterile technique; the urine and all things that come in contact with it are completely free of all microorganisms.

Steps of Procedure for Collecting a Midstream Clean-Catch Urine Specimen

1. Wash hands.
2. Assemble necessary equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy.
7. Allow client to collect specimen if he or she can do so. Assist client if necessary.
8. Offer bedpan or urinal or assist client to bathroom or bedside commode.
9. Wash hands.
10. Put on gloves and goggles.
11. a. Male - Clean penis carefully with towelettes or washcloth and soap.
    b. Female - Clean perineal area by separating labia; wash one side of labia, front to back and discard towelette. Repeat on other side of labia. Complete cleaning by washing down the center, front to back, across the uretheral opening.
12. For female client, keep labia separated until specimen is collected. For uncircumcised male, keep foreskin pulled back until specimen is collected.
13. Ask client to begin urinating.
14. Ask client to stop urine stream.
15. Hold specimen container where it will catch urine stream. Be sure container does not touch client. If container touches client, it is contaminated and procedure must be repeated.
16. Ask client to start urinating again. If client cannot stop urinating, move container into stream to collect midstream specimen.
17. Ask client to stop urine stream when specimen has been collected. Remove specimen container and allow client to finish urinating.

18. Put lid on container immediately. DO NOT TOUCH inside of lid.
19. Label specimen container. Record date and time of collection.
20. Place container in plastic sack. Do not contaminate outside of sack.
21. Clean penis or perineal area with wet washcloth and dry thoroughly.
22. Remove, clean and store equipment. Discard disposables in proper receptacles.
23. Remove gloves and goggles and appropriately dispose of gloves.
24. Wash hands.
25. Give client clean, wet washcloth to wash hands.
26. Place soiled washcloth in appropriate container.
27. Wash hands.
28. Make client comfortable.
29. Place call device within reach, if appropriate.
30. Take urine specimen to designated area.
31. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Collecting a 24-Hour Urine Specimen

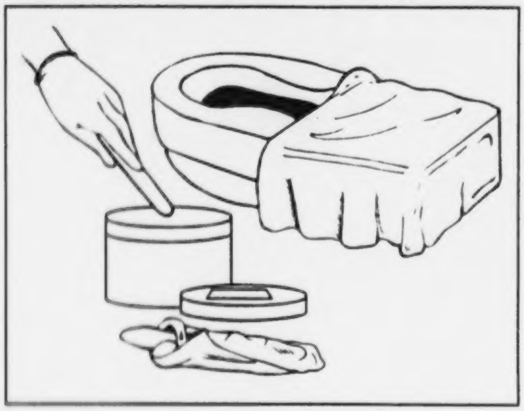
1. Wash hands.
2. Assemble necessary equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy.
7. Place large labeled specimen container in bathroom. To control odors and bacterial growth, place container in ice bucket or obtain preservative from laboratory. NOTE: If ice is used, replace as necessary.
8. Place tags by client's bed and in client's bathroom to alert all personnel that 24-hour specimen is being collected.
9. At beginning of collection period, have client void and discard urine to make sure bladder is completely empty. (NOTE: Use steps of procedure for assisting client with urinal or bedpan.) Record time to start 24-hour collection period, which will continue until same time next day. Collect all other urine voided during this period.
10. Offer bedpan or urinal, or assist client to bathroom or bedside commode.
11. Wash hands.
12. Put on gloves and goggles
13. Ask client to void. DO NOT discard toilet tissue in bedpan or collecting utensil; provide plastic bag or wastebasket for toilet paper. Remind client not to have bowel movement, if possible.
14. Remove bedpan or urinal, or assist client back to bed, if necessary.
15. If client's fluid intake and output are being recorded, measure and record amount of urine each time client voids.
16. Pour urine into large container. NOTE: If any urine is spilled or discarded, test must be restarted.
17. Clean penis or perineal area with wet washcloth and dry thoroughly.
18. Remove, clean and store equipment. Discard disposables in proper receptacles.
19. Remove gloves and goggles and appropriately dispose of gloves.
20. Wash hands.
21. Give client clean, wet washcloth to wash hands.
22. Place soiled washcloth in appropriate container.
23. Wash hands.
24. Make client comfortable.
25. Place call device within reach, if appropriate.
26. At end of collection period, take specimen and laboratory slip to laboratory. Remove 24-hour tags.

27. Record pertinent observations and report unusual occurrences to supervisor.

Steps of Procedure for Collecting a Sterile Urine Specimen from a Closed Urinary Drainage System

1. Wash hands.
2. Put on gloves.
3. Assemble necessary equipment.
4. Identify and greet client.
5. Identify self.
6. Explain what you are going to do.
7. Provide privacy.
8. Close clamp on drainage tubing below speci-port. NEVER leave bedside at this time without unclamping tubing.
9. Cleanse speci-port with alcohol sponge.
10. Remove needle cover from syringe.
11. Insert needle into speci-port and gently pull back on plunger to obtain required amount of urine.
12. Remove needle and syringe from speci-port. Cleanse speci-port with alcohol sponge.
13. Open clamp on drainage tubing. Check to see that urine is draining into drainage bag.
14. Place needle of syringe into specimen container and push plunger to expel urine into container.
15. Close container tightly. Label container.
16. Pour leftover urine into toilet or hopper.
17. Remove, clean and store equipment. Discard disposables in proper receptacles.
18. Remove and appropriately dispose of gloves.
19. Wash hands.
20. Make client comfortable.
21. Place call device within reach, if appropriate.
22. Take specimen to designated area.
23. Record pertinent observations and report unusual occurrences to supervisor.

Figure 5.2 - Collecting a Stool Specimen



A second type of specimen that the nurse assistant will probably be asked to collect is a fecal specimen. Feces, (as defined in Lesson 3), are the solid waste products of the digestive system and are composed of undigested food, bacteria, mucus and water. Other terms used to refer to feces are stool or bowel movement. Feces collect in the rectum and are eliminated by defecation through the anus. The nurse assistant must follow specific instructions when collecting a **stool specimen**, which is a sample of stool taken from the client for laboratory evaluation, see Figure 5.2. Some tests will require that this specimen still be warm when it is examined. The nurse assistant should make sure it is taken to the laboratory immediately. Feces are commonly tested for **occult blood**, unseen or hidden blood. Blood may appear in the feces for many reasons. Colon cancer, ulcers and polyps are some disorders that can cause the presence of blood in feces. Blood is easily detected if it is from low in the digestive tract; if it comes from high in the digestive tract, it will cause the stool to have a tarry or black appearance. If bleeding occurs in small amounts, the blood is usually difficult to detect. Feces may also be examined for the presence of parasites, pathogens or fat deposits.

Steps of Procedure for Collecting a Stool Specimen

1. Wash hands.
2. Put on gloves.
3. Assemble necessary equipment.
4. Identify and greet client.
5. Identify self.
6. Explain what you are going to do.
7. Provide privacy.
8. Give client bedpan or assist to bedside commode or to bathroom fitted with speci-pan.
9. Ask client not to urinate or put toilet tissue into receptacle. Provide plastic bag or wastebasket for toilet paper.
10. Give client clean, wet washcloth to wash hands, if necessary.
11. Place soiled washcloth in appropriate container.
12. Take covered bedpan to client's bathroom or to dirty utility room.
13. Using wooden tongue depressor, take about one to two tablespoons of feces from different areas of stool and place into specimen container. DO NOT TOUCH inside of lid or container.
14. Cover specimen container securely and label container.
15. Place container in plastic bag for transporting to laboratory.
16. Empty remaining stool into toilet or hopper.
17. Remove, clean and store equipment. Wrap tongue depressor in paper towel and discard it and other disposables in proper receptacles.
18. Remove and appropriately dispose of gloves.
19. Wash hands.
20. Make client comfortable.
21. Place call device within reach, if appropriate.
22. If specimen is not sent to lab immediately, store according to acility's policy. Stool specimens are NEVER refrigerated.
23. Record pertinent observations and report unusual occurrences to supervisor.

Sputum, which is a mucous secretion expelled from the lungs, bronchial tubes or trachea, may also be collected. It is examined for bacteria, pus, blood and other abnormal cells. Sputum is thick and must be coughed up from the bronchial tubes and lungs. Some health care facilities have a staff member from the Respiratory Therapy Department collect this specimen, while a home health aide or a caregiver will have to perform this procedure in a home health setting. A sputum specimen should also be collected at a specified time. Usually, early morning is the best time to collect this type of specimen. The nurse assistant must be sure that the specimen collected is sputum and not saliva. **Saliva** is a clear, thin secretion of the salivary glands that helps moisten food and aids in swallowing. It also contains an enzyme that helps start the digestion of food.

Steps of Procedure for Collecting a Sputum Specimen

1. Wash hands.
2. Put on gloves.
3. Assemble necessary equipment.
4. Identify and greet client.
5. Identify self.
6. Explain what you are going to do.
7. Provide privacy.
8. Have client rinse out mouth with water and spit into emesis basin.
9. Have client hold container. Instruct him or her to only touch outside of container.
10. Tell client to take three deep breaths in a row, and on third, exhale and cough deeply from within lungs to bring up sputum. Have client cover

mouth and nose with tissue when coughing.
11. Have client spit sputum directly into container.
12. Collect one to two tablespoons of sputum. Client may need to cough several times to bring up this amount of sputum.
13. Immediately put lid on container.
14. Label container. Record date and time of collection.
15. Remove, clean and store equipment. Discard disposables in proper receptacles.
16. Remove and appropriately dispose of gloves.
17. Wash hands.
18. Make client comfortable.
19. Place call device within reach, if appropriate.
20. Take specimen to designated area. Sputum MUST BE tested before it begins to dry.
21. Record pertinent observations and report unusual occurrences to supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 5: Specimen Collection

Activity Sheet

1. Why does the doctor order specimens to be sent to the laboratory?

   ____

   ____

2. How is asepsis maintained when handling specimens?

   ____

   ____

3. What is a clean-catch midstream urine specimen collection?

   ____

   ____

4. When does 24-hour urine specimen collection begin and end?

   ____

   ____

5. How much fecal matter is collected for a stool specimen? From where should the specimen be taken?

   a. ______________________________

   b. ______________________________

6. How much sputum should be collected for a sputum specimen?

   ____

Clinical/Laboratory Activities

1. Practice using the equipment for specimen collection. Peanut butter can substitute for a stool specimen, apple juice, weak tea or tinted water can be used for urine and thinned liquid starch can be used for sputum.

2. Practice applying labels to specimen containers.

Lesson 6:
Applying Heat and Cold

Objectives:

A. Identify safety measures to follow when applying heat and cold.

B. Identify the purpose and uses of heat applications.

C. Identify the types of heat application.

D. Identify signs of complications of heat application.

E. Apply warm, moist compress.

F. Apply warm water bottle.

G. Apply aquathermia pad.

H. Identify the purpose and uses of cold application.

I. Identify the types of cold applications.

J. Identify signs of complications of cold application.

K. Apply ice bag or ice cap.

Key Term:

- Aquathermia pad

Heat and cold applications are ordered by a doctor and directed by the supervising nurse. These applications may be applied to any area of the body to help speed up the healing process or to warm up or cool down the body.

Safety Measures for Heat or Cold Applications

Safety should always be a major priority. Burns may result from either warm or cold applications. The nurse assistant should always complete the following measures in order to maintain safety during heat and cold applications.

Check applications frequently. *The first check should be made five minutes after the initial application and then as requested by the supervisor.*

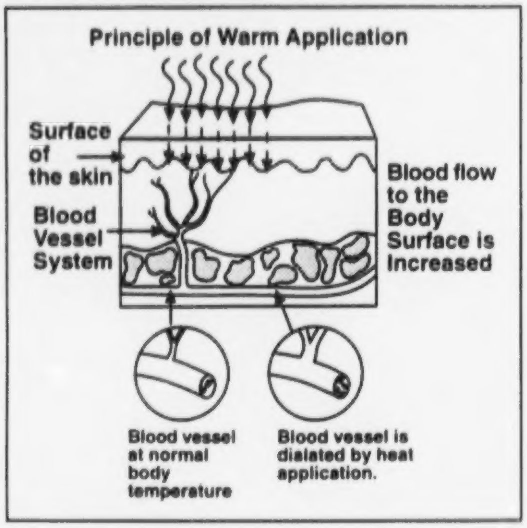
Maintain all electrical devices in good operating condition. Any electrical device that will be used should have no frayed cords. If cords are frayed, the possibility of an electrical shock exists.

Maintain all equipment that uses water in good operating condition. Any time water is being used for a treatment, the nurse assistant should make sure there are that no leaks in the equipment. If there is a leak or the stopper is loose, a client could be lying in a wet bed.

Use correct temperature levels and check levels frequently. The nurse assistant should always make sure the temperature is correct whether there is a control or not, such as on a heating pad. A thermometer should be used to check water temperature, which is the most accurate method. If a thermometer is not available, the nurse assistant can test water temperature by touching it with the inner side of his or her wrist. It is difficult to maintain water temperature, so it should be checked frequently.

Monitor application time accurately. The nurse assistant should know how long an application is to be left in place. This information should be given to the nurse

Figure 6.1 - Heat Application


Principle of Warm Application
Surface of the skin
Blood Vessel System
Blood flow to the Body Surface is Increased
Blood vessel at normal body temperature
Blood vessel is dilated by heat application.

assistant by the supervising nurse. If it is not provided, the nurse assistant should ask for it. Since the weight of a warm water bottle or an ice bag can create additional pressure on an already tender area, the nurse assistant should monitor the application time accurately.

Provide comfort and privacy during application. The nurse assistant should only expose the body part where the application is to be placed. This will prevent the client from becoming chilled and being overexposed, especially if the area to be treated is close to or on the trunk area of the body. This will also provide privacy for the client while the treatment is in progress.

Place call device within the client's reach. Since a client will generally be confined to his or her bed during a treatment, the nurse assistant should make sure that the call device is within reach, as it should be at all times. Home health clients may need to use a whistle, a small hand bell, or maybe even a pan and spoon as a signaling device.

Know how to operate any type of equipment that is to be used for the treatment. If the nurse assistant has not operated the equipment being used in the treatment, or it has been a while since he or she has operated it, check with the supervisor for instructions. This will give a client more confidence in the nurse assistant's ability. If a client or family member is going to use a piece of equipment, the nurse assistant should check to make sure they know how to use it properly, including all safety precautions. Many health care facilities or agencies have special policies regarding the use of electric heating pads, heat lamps, as well as other equipment. The nurse assistant should be aware of these policies and follow them when using any specialized equipment.

Keep metal or plastic parts of equipment away from a client's skin. Anytime the nurse assistant is applying equipment that contacts a client's skin, he or she must be aware that metal and pastic parts will be much warmer or colder than the application and could cause a serious burn. Many health care facilities have special covers to protect both the equipment and the client. In the home, pillow cases or towels can be used to protect a client's skin.

Take extra precautions when caring for an unconscious client. Unconscious clients have no way of telling the nurse assistant that he or she is experiencing discomfort. Close monitoring of the client's body area being treated is critical in preventing burns.

Purpose and Uses of Heat Applications

When heat is applied to the body, it causes the blood vessels to dilate and bring more blood to the area as shown in Figure 6.1. This in turn will bring more oxygen and nutrients into the area to increase healing. Warm soaks or compresses may be ordered for a client when he or she has an area of inflammation. The extra blood brought in from heat application when vessels dilate will help carry away excess fluids caused by injury or inflammation.

Many people with arthritis are helped when heat is applied to inflamed joints. Heat may be used to relieve or reduce pain by relaxing muscles that may be in spasm. It may also be used to provide warmth and comfort.

Types of Heat Application

There are two types of heat application, moist and dry. In moist applications, the moisture will touch the skin. Heat may be applied to the entire body by placing a client in a tub of warm water. *Water is a good conductor of heat; therefore, the effects from any type of moist heat are greater and will occur much faster than with a dry application.* Heat will also penetrate deeper with a moist application so applications should be checked frequently to prevent tissue damage. In a dry application, no moisture touches the skin because the water is inside the equipment or an electrical appliance is used. The dry heat application will stay at the desired temperature longer because heat is not lost through evaporation. *Because dry heat does not penetrate as deep as moist heat, the risk of burns is somewhat decreased. However, higher temperatures are used to gain the desired effect, so the risk of a burn remains.*

Temperatures will vary for the type of application used and the results desired. The temperature of the application is determined by a physician or physical therapist. Several types of warm, moist and warm, dry applications are listed in Figure 6.2 including an aquathermia pad. An **aquathermia pad** is a waterproof plastic or rubber pad that contains channels through which water flows. Although generally safer than a conventional heating pad, it should be checked periodically to avoid the risk of accidental burns.

Signs of Complications from Heat Applications

Even with the best of checking, complications may occur. Often with clients who are elderly, complications occur due to delicate and fragile skin, poor sensation, circulatory problems, or from confusion. Fair-skinned individuals are also at a greater risk for developing complications from local heat applications. The nurse assistant should frequently

Figure 6.2 - Types of Heat Applications

WARM, MOIST	WARM, DRY
Compresses	Water bottles (water inside)
Packs	Aquathermia pad (water inside tubing)
Soaks	Electric heating pad (no water)
Tub soak	Commercially prepared chemical packs
Sitz bath	

check for the following signs of complications: pain or sensitivity at the site of application, too much redness (darker discoloration), and/or blisters. If at any time the nurse assistant thinks a client is being burned, the application should be removed and he or she should immediately report the situation to the supervising nurse.

Steps of Procedure for Applying a Warm, Moist Compress

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy.
7. Position client in comfortable position.
8. Place waterproof bed protector under body part that is to receive moist compress.
9. Fill basin ½ to 2/3 full with hot water. Temperature should be as directed by physician or physical therapist.
10. Place compress into hot water.
11. Wring out compress so water is not dripping from it.
12. Apply to specified area and note time of application.
13. Cover compress with plastic wrap and then with bath towel.
14. Secure towel in place with ties, tape or rolled gauze.
15. Place call device within reach.
16. Check area after initial five minutes.
17. Remove moist compress after 20 minutes; pat dry with a towel.
18. Remove, clean and store equipment.
19. Wash hands.
20. Make client comfortable.
21. Place call device within reach.
22. Record observations and report anything unusual to supervisor.

Steps of Procedure for Applying a Warm Water Bottle

1. Wash hands.
2. Assemble necessary equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy.
7. Rinse warm water bottle with hot tap water; test for leaks.
8. Fill graduate with warm water and test temperature with bath thermometer. Temperature should be as directed by physician or physical therapist.
9. Pour warm water into bag until approximately ½ full.
10. Expel air from bottle.
11. Close opening.
12. Dry top and neck of bottle.
13. Apply flannelette cover or wrap in dry towel to prevent burns and to secure in place.
14. Apply as ordered.
15. Record time, temperature of water, and area to which it is applied.
16. Place call device within reach.
17. Check client's skin area and dryness of warm water bottle cover after initial five minutes and every 30 minutes thereafter to prevent burns.
18. Remove, clean and store equipment.
    a. Dry inside and outside of bottle.
    b. Store inflated in cool place.
19. Wash hands.
20. Make client comfortable
21. Place call device within reach.
22. Record observations and report anything unusual to supervisor.

Steps of Procedure for Applying Aquathermia Pad

1. Wash hands.
2. Assemble necessary equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.

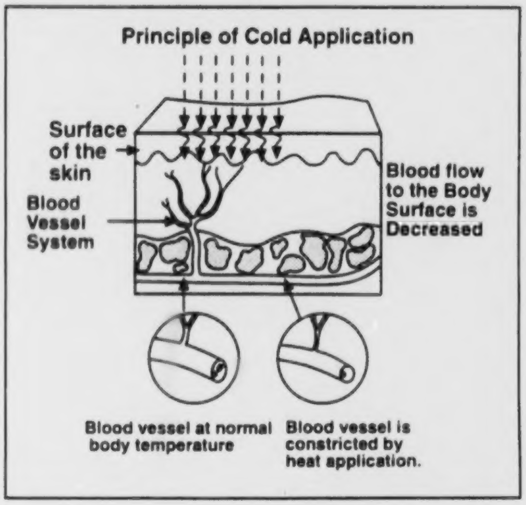
6. Provide privacy.
7. Place pad in cover. DO NOT USE PINS!
8. Place water reservoir container on bedside table.
9. Arrange tubing at level of pad. Do not allow tubing to hang below level of bed.
10. Very carefully and gently apply pad to body area. Note time pad is applied.
11. Check skin under pad after initial five minutes and every 30 minutes thereafter to prevent burns.
12. Remove aquathermia pad at end of treatment period.
13. Remove, clean and store equipment.
14. Make the client comfortable
15. Place call device within reach.
16. Wash hands.
17. Record time applied, length of treatment and area to which it was applied
18. Record observations and report anything unusual to supervisor.

Purpose of and Uses of Cold Applications

When cold is applied to the body, it has the opposite effect of heat. It causes the blood vessels in the area to constrict (become narrow) and thus reduces the circulation to that area as shown in Figure 6.3. Reduced circulation decreases the amount of oxygen and nutrients to the area, which also reduces the amount of toxic substances and waste products produced through tissue metabolism. This reduction results in less swelling in the area.

When cold is applied to the entire body, it is usually done to reduce a high body temperature. This may be done by placing a client in a tub of cool water or by using equipment such as a hypothermia blanket. Cold applications are used to control bleeding by blood vessel constriction, which reduces the amount of bleeding and prevents swelling. Cold will also reduce or relieve pain in an area through a numbing effect. When a cold application is used, the skin in the area of the application will appear pale and feel cool because of decreased blood flow.

Figure 6.3 - Cold Application


Principle of Cold Application
Surface of the skin
Blood Vessel System
Blood flow to the Body Surface is Decreased
Blood vessel at normal body temperature
Blood vessel is constricted by heat application.

Types of Cold Applications

There are two types of cold application, moist and dry. In a moist application, the moisture will touch the skin, such as a cold compress or a cold tub bath or sponge bath. *Water is a good conductor of cold; therefore, the effects from any type of moist cold are greater and will occur much faster than with a dry application.* As in warm moist applications, cold moist applications will also penetrate deeper than dry applications, so applications should be checked frequently to prevent tissue damage. In a dry application, no moisture will touch the skin. The water in dry applications is inside the equipment such as when ice is used in a water bottle. *Because dry cold does not penetrate as deep as moist cold, the risk of tissue damage is somewhat decreased.* However, longer *applications times are used to gain the desired effect, so the risk of tissue damage remains.*

The temperature will vary depending on the type of application and the desired results. A physician or physical therapist will determine the temperature. Several types of cold, moist and cold, dry applications are listed in Figure 6.4.

Signs of Complications from Cold Applications

Complications may occur from cold applications as well. The signs that will indicate possible tissue damage include: pain, cyanosis (bluish or purplish skin color), and burns and blisters. When cold applications remain in place for long periods of time, the blood vessels may have a tendency to dilate. When this happens, blood flow increases and will consequently have the same effect as a heat application. Whether applying heat or cold, the nurse assistant should always be alert and observant to prevent a complication from occuring.

Steps of Procedure for Applying an Ice Bag or Ice Cap

1. Wash hands.
2. Assemble necessary equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Provide privacy.
7. Test equipment for leaks by filling with water.
   NOTE: This is usually done outside client's area.
8. Use clean basin and scoop or spoon to collect ice.
9. Fill ice bag or ice cap ½ to 2/3 full.
10. Expel all air.
11. Dry outside of bag or cap. NOTE: If moisture is left on bag, it may penetrate and cause injury.
12. Apply cover (fitted wrapper or towel pinned around equipment).
13. Apply bag or cap against indicated area.
14. Place call device within reach.
15. Check the client's skin for signs of complications after the first five minutes; continue checking every 30 minutes until treatment is discontinued.
16. Remove bag or cap when time has elapsed.
17. Discontinue application at two-hour intervals or per physician's order.
18. Remove, clean and store equipment.
    a. Dry exterior.
    b. Hang upside-down with cap open.
    c. Store appliance inflated and closed in cool place after drying.
19. Wash hands.
20. Make client comfortable
21. Place call device within reach.

Figure 6.4 - Types of Cold Applications

COLD, MOIST	COLD, DRY
Compresses	Ice caps or ice collars (water or ice inside)
Packs	Water bottles (water or ice inside)
Soaks	Commercially prepared chemical packs
Tub bath	

22. Record observations and report anything unusual to supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 6: Heat and Cold Applications

Activity Sheet

1. List six safety measures used with heat or cold applications.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

   e. ______________________________

   f. ______________________________

2. How frequently should a heat or cold application site be checked?

   ____

   ____

3. Why is it particularly important to closely monitor an unconscious client?

   ____

   ____

   ____

4. What happens to the blood vessels when heat is applied?

   ____

   ____

5. What are two reasons for applying heat?

   a. ______________________________

   b. ______________________________

6. Why should a moist heat application site be checked frequently?

7. Why should a dry heat application site be checked frequently?

8. Name four types of heat applications?

a. ______ c. ______

b. ______ d. ______

9. List three signs of complications from heat applications?

a. ______

b. ______

c. ______

10. What happens to the blood vessels when cold is applied?

11. What are two reasons for applying cold?

a. ______

b. ______

12. Why should a moist cold application site be checked frequently?

13. Why should a dry cold application site be checked frequently?

____

____

____

14. Name four types of cold applications?

a. ____________________ c. ____________________

b. ____________________ d. ____________________

15. List three signs of complications from cold applications?

a. ____________________

b. ____________________

c. ____________________

Clinical/Laboratory Activities

1. At the clinical site, observe the different types of heat and cold applications that are applied. Discuss your findings with the class.

2. Practice preparing heat and cold applications for different temperatures.

3. Practice applying the following heat and cold applications:

   a. Warm, moist compress
   b. Warm water bottle
   c. Aquathermia pad
   d. Ice bag or ice cap

Lesson 7:
Wound Care

Objectives:

A. Describe types of wounds and lesions.

B. Identify characteristics of wounds and their drainage.

C. Discuss basic wound care.

D. Perform clean, nonmedicated dressing changes.

E. Describe the main cause of pressure ulcers.

F. Identify common sites where pressure ulcers are most likely to develop.

G. Discuss the stages of the development of pressure ulcers.

H. Identify clients who are more prone to developing pressure ulcers.

I. Describe ways the nurse assistant can help prevent pressure ulcers.

J. Give pressure ulcer care.

Key Terms:

- Wound
- Incision
- Sutures
- Staples
- Excoriation
- Skin tears
- Lesion
- Pustule
- Crust
- Vesicle
- Scab
- Necrotic
- Wound care protocol
- Dressing
- Sterile
- Clean technique
- Pressure ulcer

Unbroken skin is one of the body's defense mechanisms. Unfortunately, cuts, tears, burns and other wounds, even surgical incisions may occur, opening the skin for the entrance of microorganisms. The nurse assistant should be careful not to inflict wounds accidentally and to prevent the occurrence of pressure ulcers. If wounds do occur, wound care should be initiated immediately so that the skin regains its unbroken state and infections do not occur.

Types of Wounds and Lesions

The term **wound** usually refers to a physical injury involving a break in the skin, either accidental or deliberate, such as when it is twisted, bumped or cut during surgery. A surgical wound may be a deliberate cut, called an **incision**, or it may be a stab wound where drainage tubes are inserted. An incision usually has **sutures**, a special type of thread with which surgical wounds are sewn together, or **staples**, metal bands that hold the wound together after the surgey is completed. A stab wound made during surgery is usually not very large, and thus does not need to be sown or stapled together. It will scab over when the drainage tubing is removed. An **excoriation** is a wound caused by scratching or by any means where portions of the skin are scraped away. Clients who are elderly or others who have very thin and fragile skin may experience **skin tears**. Skin tears are a shearing open of the top layers of skin when the skin is accidentally twisted or bumped.

A **lesion** is a change in the skin due to a disease or allergic condition. A **pustule** is a lesion filled with pus and has an inflamed base, such as acne. The pustule usually breaks open, discharging the pus and forming a **crust**, an area of dried body secretions. A **vesicle** is a raised area filled with clear tissue fluid, such as a blister. A vesicle forms when a hot object, such as an iron, burns the skin. The vesicle usually breaks open; sometimes the tissue fluid is reabsorbed, then the damaged skin over the vesicle wears off. Neither pustules nor vesicles should be deliberately broken open.

Characteristics of Wounds and Their Drainage

Wounds may be open so that the underlying tissue can be seen, or they may be crusted over with dried tissue fluid that is a yellowish color. If the crusting is dark red, it is a **scab**, an accumulation of blood cells and tissue fluid. If the crusting is black, the tissue is **necrotic**, or dead. If the wound is open, the tissue should be pink. The open wound may seep tissue fluid, a clear to slightly yellow fluid, or blood, which is red to dark red in color. If the drainage is greenish, an infection is present. Normal drainage from a wound has no odor. If the drainage has an odor, it may indicate an infectious process in the wound. The borders of the wound should be watched closely since they may give an indication of whether an infection is present. If an infection is present, the tissue surrounding the wound will be red and slightly warm to the touch, and may also look puffy or swollen. A rise in temperature may also signal a wound is infected.

Wound Care

Each health care facility will have a **wound care protocol**, which is a step-by-step procedure that indicates what should be done if a client's skin is cut or torn. In general, most wound care protocols indicate that the wound and surrounding skin are to be cleaned with an antibacterial soap. Next, an antibiotic ointment is applied and the wound is covered with a light dressing. If an elderly client has received a skin tear, care should be taken when the dressing is applied because tape applied to the skin can cause even further tears when it is pulled off to change the dressing.

Since lesions are caused by some underlying disease process, treatment for them is ordered by a physician. The crusts of lesions should never be removed. Bathing and the use of lotions may not be allowed. Special baths may be ordered. The nurse assistant should check with the supervisor to learn if any alterations have been made to personal hygiene routines when lesions are present. A client should be handled gently, and rubbing of the lesions should be avoided.

Incisional wound care is ordered by a physician. When the post-operative **dressing**, the bandage used over the wound, is removed, some physicians prefer that the wound be left uncovered if no drainage is present. If wound care is required, the dressing applied is **sterile**, meaning that the dressing procedure is carried out with all supplies being free of bacteria. Usually a licensed nurse will perform any sterile dressing changes. If any wound requires medication, extensive packing or careful observation, a licensed nurse will be responsible for the wound care.

Most wounds require clean technique for applying dressings. **Clean technique** means that the dressing is kept as free as possible from contamination by bacteria, which can be done by holding the dressing only by the very edges and making sure it does not touch anything until it is placed over the client's wound. Even a Band-Aid is applied using clean technique by avoiding touching the area where the pad is as the sticky tabs are being removed. The pad area of the Band-Aid should be placed over the wound without ever having touched anything else.

If the nurse assistant is responsible for changing a nonsterile dressing, care is taken in the removal and disposal of the old dressing. The old dressing is observed for the amount and color of drainage. Care is taken that the dirty dressing does not touch the bed linens or other articles in the room. The dirty dressing is placed in a paper or plastic bag before being disposed of in the trash. This practice confines any contaminated material. Before a new dressing is applied, the wound should be observed closely for size, color, skin condition surrounding the wound, and any changes since the dressing was last changed. If signs of infection are present, the supervisor should be called to view the wound.

Steps of Procedure for Performing Clean, Nonmedicated Dressing Changes

1. Wash hands.
2. Assemble necessary equipment.
3. Identify and greet client.
4. Identify self.
5. Explain what you are going to do.
6. Wash hands.
7. Put on gloves.
8. Expose dressing.
9. Remove old dressing.
10. Observe and record (if appropriate) amount and color of drainage on old dressing.
11. Place in paper or plastic sack.
12. Observe wound.
13. Remove and appropriately dispose of gloves in paper or plastic sack.
14. Wash hands.
15. Open clean dressing.
16. Touching only edge of clean dressing, lay it over wound.
17. Apply tape.
18. Make client comfortable.
19. Place call device within reach, if appropriate.
20. Remove, clean and store equipment.
21. Discard soiled dressing in appropriate container.
22. Wash hands.
23. Record pertinent observations and report unusual occurrences to supervisor.

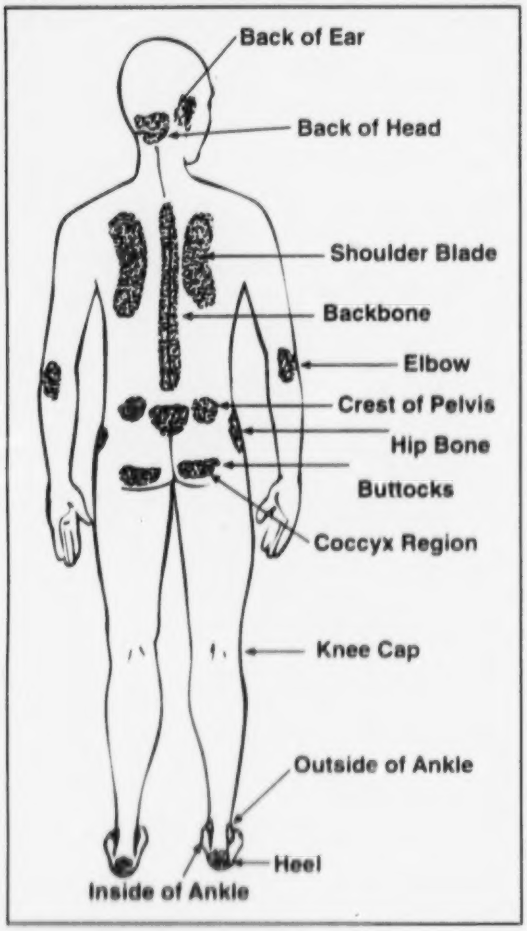
Pressure Ulcers

A **pressure ulcer** is an inflammation, sore or lesion that develops when skin and tissues underneath are injured due to a lack of blood flow. The lack of circulation usually happens because of continuous pressure on the skin over a bony prominence. Pressure is the main cause of the destruction of tissue, with heat, moisture, and irritants contributing to or hastening the development of a lesion. Any intense pressure can cause death of tissue after only ninety minutes, but it usually takes six to eight hours for tissue death to occur.

Common Pressure Ulcer Sites

A pressure ulcer usually develops where bones come close to the surface of the body. The common sites are the coccyx, hipbones, ridges of the spine, heels, shoulder blades and over the bones on the inside and outside of the ankles. The back of the head and the elbow are also possible sites. A pressure ulcer can occur in folds of skin

Figure 7.1 - Common Pressure Ulcer Sites



tissue also, such as in the fold under the buttocks and behind the ear. Figure 7.1 shows where pressure ulcers may develop on a client's body.

Pressure Ulcer Stages

A pressure ulcer develops in stages. In Stage I, the skin is red and tender and may be slightly warm to the touch. The skin has no breaks. This stage is easily reversed if the pressure is relieved and circulation is promoted to the area. In Stage II, the skin becomes bluish in color and has a mottled appearance. The top layer of skin may be blistered or broken and drainage of tissue fluid may be present. In Stage III, the pressure ulcer is obviously an open sore with all layers of skin involved. In Stage IV, the destruction of tissue extends down to the muscle and/or bone. Drainage is present and the top of the ulcer may be covered with a black crust as described earlier in this lesson, indicating the death of tissue.

Clients Prone to Pressure Ulcers

Clients may be prone to pressure sores for several reasons. Elderly clients who have poor circulation, are malnourished and have impaired mobility are prone to developing pressure ulcers. Paralyzed clients cannot move and may have sensory deficits that do not warn them when pressure is causing pain in the tissues. Thin and malnourished clients have bony prominences closer to the skin, making them more prone to developing pressure ulcers. Obese clients may develop pressure ulcers where body parts rub, which causes heat, moisture and friction. Incontinent clients who are not kept clean and dry can develop pressure ulcers due to constant dampness of the skin and irritation from urine and feces.

Preventative Measures for Pressure Ulcers

Any client who is prone to developing pressure ulcers should have the condition of his or her skin checked frequently. Preventive measures should be taken. The client's position should be changed at least every two hours. This applies to both bedfast clients and those who are sitting in a wheelchair for long periods of time. The bony prominences should be massaged gently with lotion. Massage over an already damaged area, such as a reddened area, may cause more damage to the tissue. Passive and active exercises will stimulate circulation. The skin should be kept clean and dry, and the bed linens should be free from wrinkles and other irritating substances, such as crumbs. Incontinent briefs or pads should be changed frequently, with the client's perineal area being washed and dried thoroughly before a new incontinent brief or pad is applied. Protein, vitamins and minerals should be encouraged in the diet to keep the skin in good repair, and a client should drink adequate fluids to keep the skin moist. Antipressure devices can be added to the bed for those clients who are most at risk for the development of pressure ulcers. An eggcrate foam mattress helps to distribute a client's weight more evenly. An air mattress or an alternating air pressure mattress can also be used to distribute a client's weight. The alternating air pressure mattress mechanically changes the pressure on body parts by filling up alternating sections of the mattress with air. Pads filled with gel can be placed in portions of a foam mattress to relieve pressure on bony prominences. Clients especially at risk may be placed on special beds that "float" the client on a semi-solid mass of particles through which air continually flows. Special foam or sheepskin heel and elbow protectors can be ordered to help decrease friction on these bony prominences as they rub against bed linens.

The nurse assistant is responsible for taking preventive measures and for good observation of the client's skin. Once an open sore is present, a licensed nurse is responsible for treating the pressure ulcer. A pressure ulcer is much easier to prevent than to heal and can usually be prevented with good nursing care.

Steps of Procedure for Performing Preventive Measures for Pressure Ulcers

1. Wash hands.
   NOTE: If drainage is present, gloves must be worn.
2. Assemble necessary equipment.
3. Identify and greet client.
4. Identify yourself.
5. Explain what you are going to do.
6. Check turning schedule.
7. Observe reddened areas.
8. Wash skin area with soap and water if soiled.
9. Gently massage skin around any reddened area with warmed lotion.
10. Place clean linen on bed if necessary.
11. Tighten linen (must be free from wrinkles).
12. Turn client to side listed on turning schedule.
13. Make client comfortable.
14. Place call device within reach, if appropriate.
15. Remove, clean and store equipment.
16. Wash hands.
17. Record care given, time it was given and side to which client was turned.
18. Record pertinent observations and report unusual occurrences to supervision.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

Lesson 7: Wound Care

Activity Sheet

1. What is the difference between a wound and a lesion?

   a. Wound - ____________________

   b. Lesion - ____________________

2. Define the following:

   a. Incision - ____________________

   b. Excoriation - ____________________

   c. Skin tear - ____________________

   d. Pustule - ____________________

   e. Crust - ____________________

   f. Vesicle - ____________________

3. Describe the following three different crusts that may be found over wounds.

   a. Yellow - ____________________

   b. Scab - ____________________

   c. Necrotic - ____________________

4. What does normal drainage from a wound look like?

   ____

5. If an infection is present in a wound, what will the drainage look like?

   ____

   ____

6. What is a wound care protocol?

   ____

   ____

7. What is the difference between sterile dressings and clean technique?

   a. Sterile dressings - ____________________

   b. Clean technique - ____________________

8. What procedure is followed to dispose of a soiled dressing?

9. Why does a pressure ulcer form?

10. List four common sites of pressure ulcer formation.

    a. ____________________

    b. ____________________

    c. ____________________

    d. ____________________

11. Define the four stages of pressure ulcers.

    a. Stage I - ____________________

    b. Stage II - ____________________

    c. Stage III - ____________________

    d. Stage IV - ____________________

12. List two types of clients who are more likely to develop pressure ulcers.

    a. ______________________________

    b. ______________________________

13. List four things that can be done to help prevent pressure ulcers.

    a. ______________________________

    b. ______________________________

    c. ______________________________

    d. ______________________________

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedure, practice changing a clean, nonmedicated dressing in the laboratory.

2. Working with a partner, examine his or her arms and legs for any wounds and lesions. If any are found, identify them by type.

3. Working with a partner, have him or her observe how many times you change you position in ten minutes. Now, have your partner time you for another ten minutes in which you remain seated in your desk chair with your feet flat on the floor without moving your hips or legs. Discuss with your partner how many times you moved the first time and how it felt not to be able to move as you would wish. Compare your findings of the number of times you and your partner moved with the rest of the class. Discuss how much pressure a client who could not move would experience in the two hours between the recommended position changes.

Lesson 8:
Caring for the Terminally Ill and the Deceased

Objectives:

A. Identify general principles of caring for the terminally ill.

B. Describe the signs of approaching death.

C. Identify the changes the body undergoes after death.

D. Discuss the care of a body after death.

E. Perform postmortem care.

Key Terms:

- Advance directives
- Living will
- Hospice care
- Dependent position
- Comatose
- Cheyne-Stokes respirations
- Rigor mortis
- Postmortem care

Death is a part of the cycle of life. It is the end stage of life. Death may be welcomed as a relief from pain and suffering for a client, but it causes sadness in those who are left behind. For a review, the *Health Care Assistant Core* curriculum presents a lesson on Death and Dying that discusses stages of dying, psychological needs and physical changes of a dying client.

General Principles of Caring for the Terminally Ill

The terminally ill client frequently experiences a great deal of emotional stress. The five stages of dying presented in the *Health Care Assistant Core* curriculum are denial, anger, bargaining, depression and acceptance. A client can experience any one of these five stages at any time and frequently moves back and forth between the stages. A client's family will also go through these stages in attempting to come to the realization that their loved one is going to die. Understanding each stage and the behavior that may be displayed in each will help the nurse assistant give the needed emotional support to a client and his or her family. The nurse assistant should recognize that he or she can personally go through these same stages, particularly if the dying client is well liked and has been worked with for a long time.

When working with a dying client, the nurse assistant must be a good listener. Dying is a lonely process and a client may need another person to whom he or she can voice their fears. A client may ask many questions about his or her condition, but it is not the nurse assistant's responsibility to discuss diagnoses. He or she may give false reassurance by telling a client that everything will be all right. If the client KNOWS that this is not true, he or she may loose confidence in the nurse assistant. If the client's physical condition is deteriorating, it is better to say nothing. The nurse assistant can offer more comfort by touching the client caringly instead.

Many dying clients may have indicated in advance which measures they wish to have done to prolong life, which is called an **advance directive** or a **living will**. The nurse assistant should be aware of the wishes of a client and support them. They will be noted in the plan of care. Home health aides should be aware that the families of clients may have special wishes about what information is given to the clients.

A client dying at home may have hospice care. **Hospice care** is a program that allows a dying client to remain at home and die there. Physical care is provided and the client is kept as comfortable as possible. No extraordinary means are used to prolong a client's life; the client is instead allowed to die peacefully and naturally among familiar objects and familiar people. The home health aide may be responsible for giving physical care to those clients who no longer have the strength to do their own care.

The physical care of a dying client should be focused on keeping him or her as comfortable as possible. The client's skin may be very fragile, so it must be handled gently. The client may not have the strength to move, so the client's body position should be changed frequently and linens should be kept clean and unwrinkled. Dying clients are often mouth breathers, so the nurse assistant should give mouth care frequently to provide moisture and remove secretions. The client may need assistance in removing secretions from his or her mouth and may be more comfortable with his or her head in a slightly elevated position to make breathing easier. Elimination should be monitored, as the bowels may be sluggish and the kidneys may not be working efficiently to eliminate liquid waste. As death approaches, circulation slows and the client may complain of feeling cold, particularly in the feet, legs and hands. He or she may need extra blankets for warmth. The client's extremities should not be allowed to dangle in a dependent position, where gravity causes fluid to accumulate in body tissues usually lower than the level of the heart. For example, if the client can sit up in a chair for a short length of time, the nurse assistant should elevate the feet and legs on a stool. Eating requires a great deal of energy, and the client should be given small portions more frequently to avoid exhausting him or her. Liquids should be offered at routine intervals.

Receiving a visit from their spiritual leader may comfort clients. The home health aide may need to call a priest, minister, rabbi or other spiritual advisor for a client. When the spiritual leader comes, the aide should make the client as comfortable as possible and leave them alone. The home health aide will need to know what arrangements are to be made for the body after a client dies. If appropriate, clients and family members should be asked about their wishes.

Signs of Approaching Death

The level of consciousness in a dying client varies. Some clients are very drowsy and hard to arouse while others are **comatose**, unconscious and unable to be aroused. Some clients may not lose consciousness until the moment of death. Hearing is the last sense to leave a client, who should be spoken to as if he or she can hear every word. The eyes have a glassy appearance and a staring gaze. Movement, muscle tone and sensation are lost. Peristalsis slows, and the client may be incontinent of urine if he or she is producing any, seep fecal material, or have no stool with abdominal distention. Since circulation is poor, the client's legs and feet feel cool to the touch, with the skin becoming very pale and cyanotic or mottled in color. A light film of perspiration on the skin may make the client feel clammy. The pulse is fast, weak and irregular, and the blood pressure begins to fall. The respirations may be very slow, or the client may experience **Cheyne-Stokes** respirations, in which the respirations are first rapid and shallow followed by a period of no breathing. The jaw may drop and mucus may collect in the client's throat, causing a rattling sound. The signs of death are an absence of pulse, respirations and blood pressure. The pupils are fixed and dilated.

Postmortem Changes

The body continues to undergo changes after death. The pupils become permanently dilated. The body will feel cold as heat is lost and may pass urine, feces or flatus, particularly if it is turned and repositioned. Blood will pool in any dependent part, giving a bluish-purple color to that area. **Rigor mortis**, rigidity of the body, will occur within four to eight hours after death.

Care of a Body after Death

Each facility will have a policy regarding **postmortem care**, the care of a body after death. The purpose of postmortem care is to maintain the appearance of the body. The nurse assistant should treat the body with respect. The head should be elevated slightly to prevent discoloration of the face. A pillow placed under the head provides enough elevation. The body should be kept flat on its back with the arms and legs straightened. The body should be cleaned, removing secretions and reinforcing dressings if drainage is present. The eyes should be closed. Dentures should be placed in the mouth, if possible, but they should not be forced into the mouth. If dentures cannot be placed in the mouth, they should be put in a labeled denture cup. If the client is in a hospital or a long-term care facility, the supervisor should be notified regarding any jewelry the client may be wearing. Personal possessions should be collected and given to the family or, if no family is present, to the supervisor. The body should be covered with a sheet to the shoulders. The family may want to spend some time alone with the body and should be allowed to do so after the postmortem care has been completed.

Usually when a client dies at home, the family is prepared for the death. The client's doctor, the licensed nurse from the home health agency and the funeral director are notified. The client must be pronounced officially dead. The body may need to be transported to a hospital for death to be declared. The home health aide should be aware of a client's and/or family's wishes regarding calling an ambulance and transporting the body. Many families cannot afford the expense of an ambulance and may have made other arrangements.

Postmortem care can be accomplished while waiting for the nurse, physician or ambulance to arrive. The family will need emotional support and once the responsibility to a client for postmortem care has been met, the home health aide may need to give comfort or assist the family with immediate needs or arrangements.

Steps of Procedure for Postmortem Care

1. Wash hands.
2. Put on gloves.
3. Flatten bed and straighten body.
4. Elevate head of bed slightly.
5. Close eyes by gently holding them in place a few moments.
6. Place dentures in cup and label container.
7. Cleanse body.
8. Comb hair.
9. Cover client with clean linen up to shoulders.
10. Arrange linen neatly.

11. Straighten room and remove medical equipment.
12. Provide privacy for family.
13. Remove and appropriately dispose of gloves.
14. Wash your hands.
15. Take client's jewelry and belongings to supervisor.

Test Your Knowledge: Complete the following activity sheet to test your knowledge and understanding of the materials you have studied in this lesson.

After you have completed the activity sheets, you may take the written evaluation for this section of this unit. A score of at least 80 percent indicates you have completed the material. Check with your clinical supervising staff member for skill testing. Review all units, paying particular attention to the items you missed.

Lesson 8: Caring for the Terminally Ill and the Deceased

Activity Sheet

1. What is the responsibility of the nurse assistant regarding advance directives?

   ____

   ____

2. What is hospice care?

   ____

   ____

3. Describe the physical care needed for a dying client.

   a. ______________________________
   b. ______________________________
   c. ______________________________
   d. ______________________________
   e. ______________________________
   f. ______________________________

4. Identify the signs of approaching death.

   a. ______________________________
   b. ______________________________
   c. ______________________________
   d. ______________________________
   e. ______________________________
   f. ______________________________

5. What are the changes that occur in the body after death?

   a. ______

   b. ______

   c. ______

   d. ______

   e. ______

6. What should be done in postmortem care?

   a. ______

   b. ______

   c. ______

7. When the client dies at home, what must be done in addition to providing postmortem care?

   ______

   ______

   ______

Clinical/Laboratory Activities

1. After the instructor has demonstrated the procedure, practice postmortem care on a model in the laboratory.

2. Examine a copy of a living will and/or advance directive.

3. Working in groups of three or four students, discuss your experiences with the death of family, friends, or pets. What were your emotions? What helped you work through those emotions? Share the experiences of your group with the rest of the class.

Unit Checklist

Student Name ______________________ Overall Unit Rating ________

Activity Sheet: Admission, Transfer and Discharge Rating ________

Comments: ______________________

____

____

Activity Sheet: Urinary Elimination Rating ________

Comments: ______________________

____

____

Skill Sheet: Assist Client With Urinal Rating ________

Skill Sheet: Assist Client With Bedpan Rating ________

Skill Sheet: Change a Drainage Bag Rating ________

Activity Sheet: Bowel Elimination Rating ________

Comments: ______________________

____

____

Skill Sheet: Administer an Unmedicated Enema Rating ________

Activity Sheet: Ostomies Rating ________

Comments: ______________________

____

____

Skill Sheet: Change an Ostomy Bag Rating ________

Activity Sheet: Specimen Collection Rating ________

Comments: ______________________

____

____

Skill Sheet: Collect a Midstream Clean-Catch Urine Specimen Rating ________

Skill Sheet: Collect a 24-Hour Urine Specimen Rating ________

Skill Sheet: Collect a Sterile Urine Specimen from a Closed Urinary Drainage System Rating ________

Skill Sheet: Collect a Stool Specimen Rating ________
Skill Sheet: Collect a Sputum Specimen Rating ________
Activity Sheet: Applying Heat and Cold Rating ________
Comments: ____
____
____

Skill Sheet: Apply a Warm, Moist Compress Rating ________
Skill Sheet: Apply a Warm Water Bottle Rating ________
Skill Sheet: Apply an Aquathermia Pad Rating ________
Skill Sheet: Apply an Ice Bag or Ice Cap Rating ________
Activity Sheet: Wound Care Rating ________
Comments: ____
____
____

Skill Sheet: Perform Clean, Nonmedicated Dressing Changes Rating ________
Skill Sheet: Perform Preventive Measures for Pressure Ulcers Rating ________
Activity Sheet: Caring for the Terminally Ill and the Deceased Rating ________
Comments: ____
____
____

Skill Sheet: Postmortem Care Rating ________
Written Unit Evaluation Score ________
Additional Comments: ____
____
____

Teacher Signature ______________________ Date ____________
Student Signature ______________________ Date ____________

Written Unit Evaluation

Student Name ______________________________ Date ________________

Circle the letter that corresponds to the best answer.

1. Which of these describes the hospital?

   a. A community based health care service that maintains clients in their home
   b. A community based agency which is responsible for managing all aspects of a client's care
   c. An inpatient health care agency that provides basic personal care and supervision of health care
   d. An inpatient health care agency where acute care of the client from diagnosis to treatment can be managed

2. What is the term used to describe those who use the services of a long-term care facility?

   a. Clients
   b. Patients
   c. Residents
   d. Consumers

3. The type of long-term care facility that is required to provide 24-hour care under the supervision of a registered nurse is a(n):

   a. Skilled nursing facility.
   b. Residential care facility.
   c. Full-service care facility.
   d. Intermediate care facility.

4. An accredited health care facility is one that has:

   a. Submitted to inspections and surveys.
   b. Paid a fee to a bonding insurance company.
   c. Met the standards of a national professional organization.
   d. Established eligibility for Medicare and Medicaid reimbursement.

5. Who is at the center of the health care team?

   a. The nurse
   b. The client
   c. The physician
   d. The case manager

6. Why is it important to know the job description for the nurse assistant position in which you are employed?

   a. It states specific insurance information.
   b. It tells you which community resources you can access for clients.
   c. It varies from one health care facility to another.
   d. It identifies the members of the health care team.

7. The nurse assistant in acute care usually works under the direction of a(an):

   a. Physician.
   b. Administrator.
   c. Registered nurse.
   d. Licensed practical nurse.

8. Which of the following is a current trend in the health care industry?

   a. Limited health care options for clients
   b. The formation of not-for-profit health care agencies
   c. Less knowledge of technological advances by clients
   d. Managed care offered through corporate health systems

9. Who is the first source to utilize when obtaining information about community health care resources for clients?

   a. The nearest clinic or hospital
   b. The local social services department
   c. Local city or county government offices
   d. The client's family members or closest neighbors

10. What should be done prior to giving care to clients?

    a. Allow time to prepare a mental or written list of items to be accomplished.
    b. Determine medications that will be needed for distribution to clients.
    c. Wait until a co-worker arrives to begin duties so they can help out.
    d. Consult with each client's physician prior to providing care.

Match the words in Column A with the correct definition/description from Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

Column A

____ 11. Physician

____ 12. Administrator

____ 13. Registered nurse

____ 14. Licensed practical nurse

____ 15. Certified medication technician

____ 16. Nurse assistant

____ 17. Unit secretary

Column B

a. Provides therapy to promote rehabilitation

b. Responsible for all aspects of the health care facility's operation

c. Provides assistance with activities of daily living

d. Prepares and administers medications

e. Gives orders for medications and treatments

f. Maintains the health care facility environment

g. Plans, assigns, and evaluates care under the direction of a registered nurse

h. Responsible for paperwork functions on the nursing unit

i. Plans, coordinates, assigns, and evaluates all nursing care

Match the words in Column A with the correct definition/description from Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

Column A	**Column B**
____ 18. Private health insurance	a. Provides for injuries sustained in an auto accident
____ 19. Employer provided health insurance	b. State-funded health care for those with low income
____ 20. Worker's compensation	c. Available through payroll deduction
____ 21. Auto insurance	d. Paid for by the individual
____ 22. Health maintenance organizations	e. Provides multiple types of insurance under one group plan
____ 23. Medicare	f. Federally funded insurance for those 65 and older
____ 24. Medicaid	g. Prepayment for health care
	h. Provides for job-related injuries

25. In the spaces provided, list five of the basic tasks of the nurse assistant. Five points total for the question.

a. ____________________

b. ____________________

c. ____________________

d. ____________________

e. ____________________

26. In the spaces provided, list the steps in the problem-solving process. The steps must be in the correct order and each step correctly identified and in the correct order will gain one point. Six points total for the question.

Step 1: ______________________________

Step 2: ______________________________

Step 3: ______________________________

Step 4: ______________________________

Step 5: ______________________________

Step 6: ______________________________

Written Unit Evaluation

Student Name ______________________________ Date ________________

Circle the letter that corresponds to the best answer.

1. Which of these describes a resume?

   a. A person who can provide information about the job applicant
   b. A summary of information about the job applicant
   c. A personal contact with the job source by the job applicant
   d. A verbalization of information about the job applicant

2. Who would be the best person to serve as your reference?

   a. Your uncle who has attended all your school functions and has been supportive of your career goals
   b. Your best friend who knows what courses you have taken and your academic performance
   c. A teacher who recognizes your accomplishments
   d. The boss of the summer job where you only worked six days before quitting to do something else

3. Which of the following indicates acceptable behavior during an interview?

   a. Sitting quietly and sharing information in a clear, concise manner
   b. Setting a tone of ease by introducing yourself and calling the interviewer by his or her first name
   c. Dressing in your usual casual style and taking your friend along for support
   d. Making up feasible answers to unknown questions and sounding confident

4. If a health care facility does not offer you a position for which you have interviewed, which of the following actions is the most beneficial?

   a. Ask the facility to send you the reason for your rejection in writing.
   b. Indicate a willingness to go through another interview to improve your chances of obtaining the job.
   c. State that you were not interested in the job anyway because you have better offers.
   d. Evaluate your performance for ways to improve your interviewing skills.

5. If you feel you are being discriminated on the job, who can be contacted for assistance?

   a. The accrediting agency for the health care facility
   b. The Civil Liberties Union or the Equal Employment Opportunity Council
   c. The Occupational Safety and Health Administration
   d. The administrators of the health care facility

6. Which of these would be the best way to respond to your supervisor who asks you to do a task for which you have NOT been trained?

   a. Refuse to do the task and notify the supervisor's boss.
   b. Notify the supervisor's boss and offer to do another task.
   c. Explain that you are not trained for that task and ignore the request.
   d. Explain that you are not trained for that task and offer to do another task.

7. What is the purpose of the organizational chart?

   a. Shows the lines of authority
   b. Tells whether the system is centralized or decentralized
   c. Identifies the organization of nursing care
   d. Specifies the employee's rights

8. Which of these is an external stressor?

   a. Being at a party where you don't know anyone
   b. Trying to work and go to school at the same time
   c. Driving to school in the ice and snow
   d. Knowing you have to get a "C" on the test to pass the course

9. Which of these is NOT an inappropriate method for stress management?
   a. Using over-the-counter medications
   a. Talking about the problem with your school counselor
   b. Daydreaming during lunch about going to the beach
   c. Labeling the situation as a challenge and looking for ways to solve it

10. Which is the first step in managing stress?

    a. Plan a vacation
    b. Identify the stressors
    c. Notify your supervisor
    d. Take several breaks

11. What factor during the job search can determine success in finding employment?

    a. Applying for the one job you feel you will get hired for
    b. Maintaining a positive attitude toward the process and the people involved
    c. Only applying for jobs that are advertised with reputable papers or firms
    d. Limiting applications to the jobs you have proven qualifications to perform

12. What is the first step in the employment process?

    a. Decide on a style and build a resume
    b. Find at least three people to serve as references
    c. Determine career goals
    d. Request transcripts from schools or programs previously completed

13. If you have no answer for a question on an application:

    a. Leave it blank.
    b. Call the business for instructions.
    c. Complete it the best that you can.
    d. Write non applicable (n/a) in the space.

14. At what point in an interview is the best impression made?

    a. With the initial handshake.
    b. Within the first five minutes.
    c. Just before the end.
    d. When all questions have been answered completely.

15. Health care facilities normally require a drug screening of all applicants to be done:

    a. Prior to offering employment.
    b. Prior to a criminal background check.
    c. After employment, but prior to training.
    d. Sometime within the first month of employment.

16. A health care worker has the right to expect written policies regarding:

    a. Facility description and salary ranges.
    b. Job benefits and performance standards.
    c. Facility limitations and management expectations.
    d. Employment conditions and tasks to be accomplished.

17. Safety inspection reports are:

    a. To be filed by office personnel.
    b. To be viewed with a supervisor.
    c. To be available to all personnel.
    d. To be requested at the interview.

18. When should a health care worker refuse an assignment?

    a. If there is a question about who is responsible for the task.
    b. If he or she has not been trained for the task.
    c. If he or she is not compensated for the task.
    d. If he or she does not like the task.

19. Lines of authority:

    a. Tells the supervisor for whom they are responsible.
    b. Notifies the workers of job openings.
    c. Detail job descriptions of all employees of a facility.
    d. Designate what the supervisor's job is.

20. A decentralized management system has power and authority at what level(s) in the organization?

    a. Upper level
    b. Intermediate level
    c. Lower level
    d. All levels

21. Stress is the body's response to life's demands and occurs as a real:

    a. Physiological process.
    b. Psychological encounter.
    c. Physical therapy problem.
    d. Psychological phenomenon.

22. The body will show signs of illness in which phase of stress?

    a. Alarm
    b. Reaction
    c. Resistance
    d. Exhaustion

Match the words in Column A with the correct definition/ description from Column B. Place the letter of your choice on the line to the left of the item number. The choices from Column B may be used once or not at all.

COLUMN A	COLUMN B
_____23. Functional nursing	a. One member takes responsibility for coordinating and organizing the care of clients
_____24. Team nursing	b. Authority is directed from top to bottom
_____25. Primary nursing	c. An RN coordinates care provided by all members of the health care team
_____26. Case management	d. Care is divided by tasks
	e. Uses an all registered nurse staff

Match the words in Column A with the correct definition/description from Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

COLUMN A

_____27. Stress

_____28. Stressors

_____29. External stressors

_____30. Internal stressors

_____31. Interpersonal stressors

_____32. General adaptation syndrome

COLUMN B

a. Come from environment

b. Adjustment of the body to maintain life

c. Warning signal of stress

d. Body's response to demands of life

e. Demands made by other people

f. Management techniques for stress

g. Come from within a person

h. Positive or negative demands on the body

List the answers to the following questions on the lines provided.

33. List three items that should be brought to an interview.

a.____

b. ____

c. ____

34. Name one symptom of stress in each of the five categories of stress.

a. Physical __________________________

b. Emotional __________________________

c. Cognitive __________________________

d. Social __________________________

e. Spiritual __________________________

Written Unit Evaluation

Student Name ______________________________ Date ________________

Circle the letter that corresponds to the best answer.

1. In a group, one member says during a discussion, "I don't think we have enough information to make a good decision. Let me go talk to the teacher." Which role is this person fulfilling in the group?

   a. Initiator
   b. Information seeker
   c. Coordinator
   d. Standard setter

2. In a group, one member says, "We only have ten more minutes to get this done." Which role is this person fulfilling in the group?

   a. Aggressor
   b. Harmonizer
   c. Dominator
   d. Gatekeeper

3. In a group, one member says, "This group isn't getting anything done. I wish I was working by myself because you all don't know what you're doing." Which role is this person fulfilling in the group?

   a. Blocker
   b. Recognition seeker
   c. Aggressor
   d. Dominator

4. Culture is defined as:

   a. The set of values, beliefs, attitudes and social behaviors that are shared by a group of people.
   b. An attitude, opinion or feeling about someone or something that is based on preconceived ideas.
   c. An assumption that all persons in a particular group will act, speak and believe in a certain way.
   d. The physical, mental and social changes that occur in each of the life stages.

5. Which of these actions would be INAPPROPRIATE when working with clients from cultures other than the nurse assistant's?

    a. Learning about the culture by asking questions
    b. Knowing your own prejudices
    c. Stressing the positive aspects of your own culture
    d. Sharing what you learn about the client's culture with the health care team

6. To assist a client in dealing with anxiety, the nurse assistant can:

    a. Ask a supervisor or relative of the client to speak with them about their concerns.
    b. Give the client as much information as possible about his or her care.
    c. Set routines and times to do tasks for the client.
    d. Confront the client on their behavior.

7. Which of these is an objective observation?

    a. The client complains of not sleeping well
    b. The client got up to go to the bathroom four times during the night
    c. The client says her daughter is coming from California to take care of her
    d. The client seems to be sad because no one visits

8. Why do groups exist?

    a. To create proper lines of authority
    b. It is easier to reach goals as a group
    c. Because people work better within a structured group setting
    d. Because people in them are dependent on one another in some way

9. The working phase of a group:

    a. Occurs after the task is completed.
    b. Establishes the goal(s) of the group.
    c. Involves problem-solving and goal achievement.
    d. Determines the relationships of group members.

10. Each member of the group:

    a. May play more than one role during a group encounter.
    b. Assumes his or her role based solely on their job title.
    c. Can play only one role at anytime.
    d. Takes a turn being the leader.

11. The client views him or herself as a customer when:

    a. They are filling out their meal menu.
    b. They are interacting with visiting family members.
    c. They spend time with other clients outside of their room or unit.
    d. They feel they have the right to expect health care to be of high quality.

12. Positive interpersonal relationships among group members:

    a. Exist in all health care settings.
    b. Helps them work more effectively.
    c. Creates suspicion about group members.
    d. Undermines the role of group leaders.

13. An effective health care worker:

    a. Follows the golden rule.
    b. Is a natural-born leader.
    c. Assumes what it is that makes each client different.
    d. Encourages clients to see things from their perspective.

14. Emotions are:

    a. Unavoidable and uncontrollable.
    b. Culturally diversified in American life.
    c. Feelings with psychological and physical aspects.
    d. Feelings determined by hereditary and cultural norms.

15. Defense mechanisms are used:

    a. To avoid daydreaming and face reality.
    b. To deal with everyday positive situations.
    c. To protect a person against legal prosecution.
    d. To protect a person against feelings of discomfort.

16. What increases a client's agitation?

    a. Restraining them
    b. Discussing acceptable behavior limits
    c. Using a soft voice and slow movements
    d. Soliciting help from a supervisor to lift them

17. What is an appropriate response to an agitated client?

    a. "If you continue to scream at me I'll scream back."
    b. "I am going to leave the room so you can get yourself under control."
    c. "I'll have to tell your family about your behavior if it doesn't improve."
    d. "You may curse at me, but don't let me hear you cursing the other clients."

18. Severe depression is:

    a. An occasional feeling of sadness and hopelessness.
    b. Manifested in psychological symptoms only.
    c. A common reaction to illness or disability.
    d. Set-off by verbal or physical triggers.

19. What should be done to help a client manage his or her depression?

    a. Try to talk the client out of his or her depression
    b. Make the client do simple tasks even when he or she does not want to
    c. Actively listen to the client and determine if he or she has support systems
    d. Empathize with the client by displaying a somber mood in his or her presence

20. What determines when information about clients should be reported?

    a. Whether it is objective or subjective information
    b. The importance of the client observed
    c. What time of day the shift changes
    d. Its level of importance

21. Documentation is:

    a. Assumed treatment that is not charted.
    b. Charted or recorded information about the client.
    c. Reported to the charge nurse at all shift changes.
    d. Maintained by the accounting staff for billing purposes.

22. What is the nurse assistant's role in client teaching?

    a. To reinforce what has been taught
    b. To establish the teaching plan for each client
    c. To demonstrate only simple tasks, like getting out of bed
    d. To instruct clients on how to schedule doctor appointments

23. What are proper considerations to be used during client teaching?

    a. Use only correct, technical medical terminology
    b. Give information quickly, but in small segments
    c. Use examples of how the information will help the client
    d. Repeat the information only once so as not to confuse the client

24. How are computers used in health care?

    a. As communication tools
    b. For accounting purposes only
    c. For record keeping and accounting purposes only
    d. To provide information banks about new medications for physicians

MATCHING: Match the defense mechanisms in Column A with the correct description from Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

Column A

____ 25. Denial

____ 26. Rationalization

____ 27. Projection

____ 28. Displacement

____ 29. Suppression

____ 30. Fantasy

Column B

a. Using excuses to explain something

b. Reliance on others for emotional support

c. Daydreaming to avoid reality

d. Taking feelings out on the wrong person

e. Blocking out anything which is painful

f. Verbal or motor activity which disperses feelings

g. Blaming someone or something else

h. Refusing to acknowledge

Match the words in Column A with the correct definition/description from Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

Column A

____ 31. Group

____ 32. Group dynamics

____ 33. Norms

____ 34. Leader

____ 35. Formal leader

____ 36. Informal leader

____ 37. Self-oriented roles

____ 38. Task function roles

____ 39. Maintenance function roles

____ 40. Interpersonal relationship

____ 41. Interaction

____ 42. Therapeutic relationship

____ 43. Empathy

Column B

a. Relationship between people in a group

b. Standards of behavior adopted by a group

c. Achievement of goals of a group

d. Relate to what the group must accomplish

e. Understanding how another person feels

f. Collection of two or more people

g. One who is designated the leader

h. Relationship between health care worker and client

i. Help the group work together; keep group encouraged and on task

j. Responsible for guiding the group

k. Help person meet his or her own needs rather than those of group

l. Summarization of activities of group

m. The way members of a group interact

n. How one person behaves and another responds to that behavior

o. Other members turn to this person for guidance even though they don't have the title of leader

Match the words in Column A with the correct definition/description from Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

Column A	**Column B**
____ 44. Assessment	a. Act in which client is injured or has potential for injury
____ 45. Objective observations	b. Gathering information about a client
____ 46. Subjective observations	c. One's opinions about a client
____ 47. Incident	d. Giving information to clients
____ 48. Confidentiality	e. Keeping information about the client private
	f. Transfer of information to a new team of health care workers
	g. Facts gathered about the client

List the information requested in the test question.

49. List two characteristics which quality health care providers possess. One point for each correct answer.

a. ______________________________

b. ______________________________

Written Unit Evaluation

Student Name ________________________________ Date ____________________

Circle the letter that corresponds to the best answer.

1. What agency sets the standards for health and safety in the workplace?

   a. Centers for Disease Control
   b. Community Resource and Development
   c. Crisis Intervention Team
   d. Occupational Safety and Health Administration

2. What is the primary purpose of a risk management department in the safety program?

   a. To collect and analyze data about accidents, injuries, and illnesses in the workplace
   b. To establish medical control measures for infectious diseases
   c. To complete and file incident reports with the facility's insurance carrier
   d. To present facts on safety issues during orientation of new employees to the facility

3. To ensure safety, where should electrical cords ideally be located?

   a. In plain sight
   b. Under a rug
   c. Behind furniture
   d. Up out of reach

4. If water is spilled on the bathroom floor when washing the client's hair, the home health aide should:

   a. Place a bathroom rug over the spill.
   b. Wipe up the spill immediately.
   c. Finish washing the client's hair and clean up afterward.
   d. Clean up the spill along with the rest of bathroom floor.

5. Which of the following safety measures regarding oxygen is particularly important in the home?

   a. Keeping the oxygen at a variable flow rate
   b. Keeping replacement tubing to replace if damaged
   c. Keeping the oxygen in a cool place
   d. Avoiding the use of candles or open flames, such as a fireplace

6. What is an antidote?

   a. A poisonous substance
   b. A substance that counteracts a poison
   c. A home emergency
   d. An action of the home safety plan

7. What is a home safety plan?

   a. The route of excavation to take after an earthquake
   b. A plan for flood emergencies that is filed with the fire department
   c. A plan establishing what each person in the home will do in an emergency
   d. The identification of resources in the community which can be called upon to help in an emergency

8. When using ____________ precautions, a surgical mask should be worn when working within three feet of the client.

   a. Airborne
   b. Droplet
   c. Contact
   d. Standard

9. A worker may refuse to work:

   a. When there is danger of death or serious injury from hazards.
   b. When personal protective equipment must be used.
   c. Until attending a safety and health training program.
   d. Until his or her insurance benefits are in force.

10. A good safety program includes:

    a. Monitoring of the inspection team.
    b. Management as safety analysis team.
    c. Employee monitoring of working conditions.
    d. Management, leadership and employee participation.

11. A list of emergency numbers for community services should be:

    a. Posted on the refrigerator door.
    b. Posted near the telephone in the home for easy access.
    c. Obtained from the local emergency preparedness agency.
    d. Filed with the local fire department.

12. What is a home safety measure to follow to prevent potential hazards?

    a. Check smoke alarms annually for proper function.
    b. Replace fuses or reset circuit breakers for security.
    c. Do not use any unlabeled substance.
    d. Operate unfamiliar equipment with caution.

13. What is the most dangerous aspect of a fire?

    a. Hot door knobs
    b. Flames and smoke
    c. Falling debris and heated air
    d. Moving ambulatory clients safely

14. When evacuating during a fire:

    a. Doors should be closed as you leave each room of the house.
    b. Wait for the fire department personnel to remove bedfast clients.
    c. Windows should be opened to allow smoke to escape.
    d. Mouths should be covered with dry towels to prevent smoke inhalation.

15. The safest place during an earthquake:

    a. Is under a bed.
    b. Is at a shelter.
    c. Is outside.
    d. Is in the basement.

16. In the event of an emergency during a home visit, the home health aide should:

    a. Contact a supervisor immediately.
    b. Remain with a client if tornado sirens sound.
    c. Go to the nearest neighbor's home for assistance.
    d. Contact the client's closest relative to assume the client's care.

17. The weakened, bedfast client is particularly susceptible to:

    a. Tuberculosis.
    b. Medication resistant drugs.
    c. Hepatitis.
    d. Pneumonia.

18. Gloves should be used by the home health aide:

    a. When there are no paper towels to dry hands with.
    b. When there is no water source in the client's home.
    c. If the client is infectious and incontinent.
    d. At all times due to the unsterile environment.

19. What precautions should the nurse assistant take to avoid personal safety hazards?

    a. Contact Precautions
    b. Wear gloves at all times
    c. Question unfamiliar employees in unauthorized areas
    d. Avoid poorly lighted areas during late night shifts

20. Standard precautions are used by the nurse assistant:

    a. At all times when dealing with clients.
    b. Only with clients who are very ill.
    c. When the potential for violent behavior exists.
    d. As ordered by the supervisor or charge nurse.

21. The preferable method of hand washing in the home is:

    a. Using bar soap and a hand towel.
    b. Using liquid soap and paper towels.
    c. Using waterless antibacterial products.
    d. Using liquid soap and air drying hands.

22. A developmental crisis is:

    a. Caused by extremely stressful circumstances.
    b. The most common crisis in health care settings.
    c. Related directly to a person's stage of life.
    d. Related directly to a person's emotion state.

23. Which of the following is a situational crises?

    a. A traumatic accident
    b. Graduating from high school
    c. Growing older
    d. Getting married

24. The purpose of crisis intervention is to:

    a. Offer the client reassurance through empathetic statements.
    b. Reduce the stress felt by the client.
    c. Discover the source of depression in the client.
    d. Understand the emotional state of the client.

Match the hazards in Column A with the correct examples in Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

	COLUMN A		**COLUMN B**
____ 25.	Biological/infectious	a.	Safe equipment
____ 26.	Chemical	b.	Accidents
____ 27.	Environmental/mechanical	c.	Medications
____ 28.	Ergonomic	d.	High-pressure assignments
____ 29.	Physical	e.	Hepatitis
____ 30.	Psychosocial	f.	Electrical shock
		g.	High beds

Match the infections in Column A with the correct descriptions in Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

	COLUMN A		**COLUMN B**
_____ 31.	Nosocomial	a.	Virus affecting the liver producing flu-like symptoms
_____ 32.	Human immunodeficiency virus	b.	Infection acquired in a health care facility
_____ 33.	Acquired immunodeficiency syndrome	c.	Virus that attacks the cells and impairs the body's immune system
_____ 34.	Hepatitis B	d.	Multidrug-resistant organism
_____ 35.	Tuberculosis	e.	Bacterial, viral or fungal disease causing inflammation of the alveoli
_____ 36.	Pneumonia	f.	Bacterial infectious disease spread by airborne droplets
		g.	A condition caused by a virus and called this when visible symptoms appear in the last stages of infection

Written Unit Evaluation

Student Name ______________________________ Date ______________

Circle the letter that corresponds to the best answer.

1. Personal care activities include:

   a. All of the activities of daily living.
   b. All activities that involve caring for the human body.
   c. Only activities involved in providing medical care.
   d. Only activities that the client cannot do alone.

2. Which of the following is a general consideration for providing personal care?

   a. Each person has his or her own routine for accomplishing personal care activities.
   b. The nurse assistant should be encouraged to perform as much of the personal care as possible.
   c. If one client does not have an item of personal care equipment, it can be borrowed from another client.
   d. Privacy is generally not required when providing personal care.

3. In order to plan personal care activities for a client, the nurse assistant must know:

   a. What the client can accomplish.
   b. Exactly how long each procedure will take.
   c. How long all the other care givers take to complete the same procedure.
   d. What other clients can accomplish.

4. Which of the following is NOT a consideration when planning personal care activities?

   a. A client's plan of care or medical record
   b. The schedule of meals and therapy
   c. The nurse assistant's needs
   d. A client's needs

5. How does the nurse assistant determine which clients require assistance with personal care activities?

   a. By performing activities according to previous contact
   b. By fulfilling all requests of clients for assistance
   c. By helping clients according to how much time they take
   d. By being told by the supervisor or observing a client

6. Which of the following is an adaptive measure for performing personal care activities for a client with paralysis?

   a. Position the client on his or her paralyzed side as much as possible.
   b. Use the terms "good side" and "bad side" when giving care.
   c. Handle the affected side or extremities with care, supporting the affected joints.
   d. Insist that the client follow the standard procedures for all personal care activities.

7. What are the most important observations the nurse assistant should make when providing personal care assistance to clients with diabetes?

   a. Skin breakdown, lesions or tears
   b. Pain and swelling in the joints
   c. Irritability and fatigue
   d. High anxiety and too communicative

8. What should the nurse assistant do when assisting a client who has arthritis with personal care activities?

   a. Force affected joints just past their range of motion.
   b. Allow for periods of activity followed by periods of rest.
   c. Complete all the personal care activities for the client.
   d. Do the activities as quickly as possible.

9. What should the nurse assistant do when assisting a client in pain with personal care activities?

   a. Ignore the client's complaints about pain.
   b. Complete the procedures as quickly as possible.
   c. Make sure that the client completes painful personal care activities.
   d. Incorporate rest periods into the procedures.

10. Before inserting a hearing aid:

    a. Wash the entire hearing aid in water.
    b. Turn the volume to its highest position.
    c. Make sure the hearing aid is turned off.
    d. Turn the hearing aid on.

11. What is an appropriate way to clean a hearing aid?

    a. Use alcohol to clean all hearing aid surfaces.
    b. Use a sharp object to clean hearing aid openings.
    c. Wipe daily with a clean, slightly damp cloth.
    d. Wash the hearing aid with water and soap.

12. What type of hearing aid is worn in the ear?

    a. Intrauricular aid
    b. Behind-the-ear aid
    c. Eyeglass aid
    d. Body-worn aid

13. How should the nurse assistant check to see if the battery of a hearing aid has power?

    a. Put the battery in with the positive and negative poles matching those on the hearing aid.
    b. Turn the switch off and on.
    c. Check to see how well the client hears when the hearing aid is in the ear.
    d. Turn the volume control on fully and listen for a whistle or a squeal.

14. What is an appropriate way to clean eyeglasses?

    a. Use alcohol to clean the lenses and the frames.
    b. Use a tissue or paper towel to dry the lenses.
    c. Use mild soap and water or eyeglass cleaning solution.
    d. Wrap eyeglasses in washcloths, towels, or other linens.

15. What is an appropriate way to clean a prothesis?

    a. Use alcohol to clean the device.
    b. Use a soft, damp cloth to wipe the device.
    c. Use a bleach solution to clean the device.
    d. Use specially formulated cleaning solutions to clean the device.

16. How should the nurse assistant hold eyeglasses when placing them on a client?

    a. By the earpieces
    b. By the corners of the frames
    c. By the nose piece
    d. By the lenses

17. Which of the following is a correct consideration for undressing clients?

    a. The nurse assistant should instruct clients on how garments are to be removed.
    b. The nurse assistant should decide what clothing a client should wear.
    c. The nurse assistant should undress a weak or non-functioning side first.
    d. The nurse assistant should undress a weak or non-functioning side last.

18. When should stockings to support circulation be applied?

    a. Before a client sits up or gets out of bed
    b. After the client gets out of bed
    c. When the client is sitting in a chair
    d. After slacks are put on

19. What is the purpose of a lap robe for clients using wheelchairs?

    a. Covers clients who cannot put on underwear
    b. Keeps client's clothing from being soiled
    c. Provides warmth and prevents exposure
    d. Hides deformities and equipment such as catheters

20. What is the primary purpose of bathing?

    a. To promote cleanliness and comfort.
    b. To relax and refresh.
    c. To assist muscle functioning.
    d. To cool body temperature.

21. What type of bath involves washing only the face, hands, axillae, and perineal area while a client is in bed?

    a. Tub bath
    b. Complete bed bath
    c. Partial bed bath
    d. Whirlpool tub bath

22. What type of bath is given to clients who are mobile and prefer being partially submerged in water?

    a. Shower bath
    b. Tub bath
    c. Partial bed bath
    d. Complete bed bath

23. Which of the following is NOT a general consideration for bathing?

    a. Observe the client's skin condition during bathing.
    b. Always wear gloves when assisting a client during bathing.
    c. Expose the client as little as possible before, during, and after bathing.
    d. Rinse soap residues thoroughly to prevent drying the skin.

24. Which of these positions for the shower chair is safest when the nurse assistant is giving a shower bath?

    a. Client sitting with unaffected side to the shower door
    b. Client sitting with chair facing the shower door
    c. Client standing with affected side to the shower door
    d. Client standing with back to the water source

25. What is the temperature range for bath and shower water?

    a. 90 ° to 105° F
    b. 100° to 110° F
    c. 75° to 85° F
    d. 90° to 115° F

26. If a client becomes faint while in the tub, which of the following should be done first?

    a. Support the client with his or her head out of the water.
    b. Cover the client with a bath blanket.
    c. Lift the client from the bathtub and return the client to bed.
    d. Drain the water.

27. Which of the following is an appropriate adaptation for the home health aide to make while assisting a client with bathing in his or her home?

    a. Purchase adaptive equipment for the shower or bath tub.
    b. Only use bathing products and equipment that the home health aide prefers.
    c. Protect bed linens and furniture surfaces from spilled water.
    d. Place bath basin and soap on the floor next to the bed.

28. When giving a complete bed bath, what part of the body should be washed first?

    a. Face
    b. Arms
    c. Chest
    d. Legs

29. When giving a whirlpool tub bath:

    a. Make sure to secure the safety straps around the client.
    b. Raise the lift to its maximum height to wash the client's feet.
    c. Fill the tub ¼ full after lowering the client into the tub.
    d. Leave the client's upper body uncovered while washing his or her feet and legs.

30. Which of the following should be done when shaving a client with a safety razor?

    a. Rinse the razor often with water.
    b. Always use upward strokes.
    c. Always use downward strokes.
    d. Apply shaving cream on one side of face, shave, then repeat for other side.

31. Which of the following is a general consideration for shaving a client?

    a. A safety razor is held at a 90 degree angle to the client's skin.
    b. Always shave with the razor that is easiest to use.
    c. Cool water softens a beard better than warm water.
    d. An electric razor should be used on clients taking anticoagulants.

32. Which of the following should be done when shaving a client with an electric razor?

    a. Apply shaving cream to the area to be shaved.
    b. Rinse the razor with water.
    c. Wash the face of any excess soap or lather.
    d. Sanitize the razor head.

33. What is the primary purpose of hair care?

    a. To stimulate circulation to the scalp
    b. To observe hair for lice or other insects
    c. To exercise the client's hands and arms
    d. To improve the client's appearance

34. Which of the following is a general consideration for giving hair care?

    a. Hair care is only done once a day.
    b. The client may become chilled more quickly with wet hair.
    c. The scalp is less sensitive to heat than the skin of the body.
    d. Tangles in the hair are brushed from the scalp to the end.

35. What is a safety precaution for giving hair care?

    a. Hair rollers and curlers can be used interchangeably between clients.
    b. Clean the comb and brush at least once a week.
    c. Water temperature for shampooing should be less than 75° F.
    d. Do not use hair dryers near a tub or over a sink full of water.

36. What is a special hair care need for clients with thick, course hair?

    a. Hair and scalp should be oiled lightly daily.
    b. Hair should be washed daily.
    c. Use a conditioning detangler to prevent tangles.
    d. A hair brush is best for working with coarse hair.

37. What is the primary purpose of oral hygiene?

    a. To remove food particles and plaque from the teeth
    b. To make the client's food taste better
    c. To get rid of the client's bad breath
    d. To make the client comfortable

38. Which of the following is a general consideration in giving oral hygiene?

    a. Only vertical strokes should be used when brushing clients' teeth.
    b. The unconscious client should be given oral hygiene every two hours.
    c. Using a mouth rinse can replace brushing teeth for conscious clients.
    d. A maximum of two minutes of brushing is required to remove plaque.

39. Which of these is a general consideration in performing denture care?

    a. Wash the dentures in hot water and brush them vigorously.
    b. Soak the dentures in cleanser before putting them in the client's mouth.
    c. Hold the dentures over a sink partially filled with water when brushing them.
    d. Keep the dentures dry when they are not in the client's mouth.

40. Which of the following is a proper procedure when assisting with oral hygiene on a conscious client?

    a. Brush the biting surfaces of the molars with a vertical motion.
    b. Brush the back surfaces of the teeth only if needed.
    c. Brush vertically along the gum line.
    d. Brush the front of the teeth using an up-and-down motion.

41. How often should a new section of floss be used?

    a. After every tooth
    b. After every two teeth
    c. After every three teeth
    d. After every four teeth

42. What should be used to clean dentures?

    a. Toothbrush
    b. Washcloth
    c. Denture brush
    d. Water only

43. What is the primary reason that nail care is given to a client?

    a. To prevent cuts and scratches
    b. To observe the client's condition
    c. To prevent skin damage and give a pleasant appearance
    d. To prevent infections from nail care products

44. Which of the following is a general consideration when giving nail care?

    a. Scissors are easier and safer to use than clippers.
    b. The nurse assistant is responsible for nail care on all clients.
    c. Soaking nails in water makes them harder to cut.
    d. Nails should be trimmed straight across.

45. Which of the following is NOT a purpose of perineal care?

    a. To remove secretions and accumulated waste products
    b. To promote a client's comfort and healing
    c. To stimulate a client's urge to urinate
    d. To prevent odors, infections, and skin breakdown

46. Which of the following is a general consideration for giving perineal care?

a. Perineal care is only done once a day.
b. Perineal care cannot be done following childbirth.
c. Perineal care should involve water that is hotter than bath water.
d. Perineal care is completed from the cleanest part of the area to the dirtiest.

47. Which of the following is a consideration when giving perineal care to an uncircumcised man?

a. The foreskin must be pulled back and the head of the penis washed.
b. Perineal care cannot be completed if an erection occurs.
c. It is not necessary to pull back the foreskin.
d. The foreskin may be left in the retracted position.

48. What is the correct procedure when giving perineal care to a client with a catheter?

a. Use the same washcloth to clean the entire perineal area.
b. Remove the catheter to clean the perineal area thoroughly.
c. Wash the catheter tubing for four inches from the urethra opening.
d. Never give perineal care to a client with a catheter.

49. Which of the following is a purpose for giving a backrub?

a. To stimulate skin breakdown
b. To realign a client's vertebra
c. To relax muscles and relieve tension
d. To observe the condition of a client's muscles

50. What should the nurse assistant look for while giving a backrub?

a. Irritated skin that blanches when pressed
b. Healthy mottled skin
c. Breaks in the skin
d. Excessive oiliness

51. Which of the following is a general consideration when giving a backrub?

a. Excessive moisture of the skin requires more frequent backrubs.
b. Using oil or lotion during a backrub decreases friction against the skin.
c. A backrub is given only after changing the position of a helpless client.
d. Gloves should always be worn when giving a client a backrub.

52. When should a closed bed be made?

a. When a client will be out of bed for a short period of time
b. Before a client returns from surgery
c. When a client is having tests performed
d. After a client is discharged

53. How is a toe pleat made?

    a. By bunching up the linen around a client's feet
    b. By making several folds in the linens
    c. By tucking the linens tightly under the mattress
    d. By folding over two inches of the linen at a client's feet

54. Which of the following is a general consideration for bedmaking?

    a. The nurse assistant should avoid stacking linens in the order of use.
    b. Linens should be shaken out as they are removed during bedmaking.
    c. The nurse assistant should check the linens for objects left in the bed.
    d. A bed with loose sheets is a comfortable bed.

55. What is the best temperature range to maintain in the health care environment?

    a. 65° to 68° F
    b. 70° to 75° F
    c. 76° to 80° F
    d. 81° to 85° F

56. Which of the following does NOT correctly describe the client's environment?

    a. For the home health aide, usually a client's bedroom and bathroom
    b. In a long-term care facility, the furniture and personal items in a client's room
    c. A client's entire home and yard in the case of a home health aide
    d In an acute care setting, the furniture in the hospital room

57. Which of the following is a general consideration for maintaining a client's environment?

    a. Housekeeping staff handles all cleaning responsibilities.
    b. Personal items should be left out when not in use in case the client wants them.
    c. The home health aide must create a home environment that meets nursing standards.
    d. All health care workers are responsible for keeping noise levels at a minimum.

Match the terms or words in Column A with the correct definition or description from Column B. Place the letter of your choice on the line to the left of the question number.

COLUMN A

____ 58. Complete bed bath

____ 59. Whirlpool bath

____ 60. Shower bath

____ 61. Combing or brushing hair

____ 62. Tub or shower shampoo

____ 63. Bed or dry shampoo

____ 64. Oral hygiene

____ 65. Flossing

____ 66. Oral hygiene for helpless client

____ 67. Fingernail care

____ 68. Toenail care

____ 69. Perineal care for female

____ 70. Perineal care for male

____ 71. Backrub

COLUMN B

a. Given either standing up or sitting in a chair

b. Uses downward strokes to stimulate the scalp

c. Care of the teeth, gums and inside surfaces of the teeth and mouth

d. Involves washing the total body while a client is in bed

e. Use circular motion to clean tip of penis and downward

f. Usually foam based that absorbs the excess oil and dirt in a client's hair

g. Performed with long, smooth strokes and circular strokes to relax muscles

h. Report to supervisor if they are long and need trimming

i. Can be given in a shower, a tub, or at any sink that a mobile client can access

j. Performed with waxed or unwaxed string

k. Has a chair that mechanically lifts a client into the tub

l. Soak in warm water for five minutes

m. Brush teeth with toothbrush moistened with diluted mouthwash

n. Wash inner genital area from front to back

Match the terms in Column A with the correct description from Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

COLUMN A	COLUMN B
____ 72. Unoccupied bed	a. Top linens are fanfolded to the bottom
____ 73. Open bed	b. Can be open or closed
____ 74. Surgical bed	c. Extra fold in top sheet
____ 75. Closed bed	d. Protects linens from dust in the environment
____ 76. Occupied bed	e. Made with a client in it
	f. An extra sheet folded in half and placed across the center of a bed
	g. Has extra protective linen on it

Lesson 2: Eyeglasses, Hearing Aids and Protheses

Skill Sheet

INSERT OR REMOVE A HEARING AID

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Hearing aid and case, if applicable

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
Inserting a Hearing Aid: 1. Wash your hands.		
2. Make sure the hearing aid is turned off and the volume is in the lowest position.		
3. Determine if the hearing aid is for the right or left ear.		
4. Line up the parts of the earmold with the corresponding part of the external ear.		
5. Insert the earmold into the external canal of the ear.		
6. Gently push the earmold into the ear canal while rotating it slightly toward the back of the ear until the earmold fits snugly and comfortably into the canal.		
7. Adjust the other parts of the hearing aid: a. Position the battery holder and amplifier portion of a behind-the-ear aid with the tubing over the top of the ear and the rest behind the ear against the skull.		
b. Position the battery holder and amplifier portion of a body-worn aid in a pocket or carrier, or clip it to the clothing or a belt with the cord lying smoothly along the neck.		
8. Turn the hearing aid on. If the hearing aid whistles, the earmold may not be inserted correctly and should be removed. Steps 4 to 7 need to be repeated.		
9. Slowly turn the volume up, at least halfway, and adjust as the client requests.		
Removing a Hearing Aid: 1. Turn the hearing aid off and lower the volume to the lowest position.		

2.	Grasp the earmold, rotating it toward the front of the ear, while pulling it outward.		
3.	When the earmold is out of the ear, unhook or unclip other parts of the hearing aid.		
4.	Store the hearing aid in a case or safe place.		

The student has satisfactorily completed the procedure "INSERT OR REMOVE A HEARING AID" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 2: Eyeglasses, Hearing Aids and Protheses

Skill Sheet

PLACE AND REMOVE EYEGLASSES

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Glasses and case, if applicable
2. Liquid soap
3. Soft cloth

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
Placement of Eyeglasses: 1. Wash your hands.		
2. Open the ear pieces of the glasses.		
3. Clean the glasses using soap and water or an eyeglass-cleaning solution.		
4. Dry the glasses using a clean, soft cloth.		
5. Hold the glasses by the corners of the frames.		
6. Guide the earpieces over the top of both ears.		
7. Push the lens frame to the top of the bridge of the nose.		
8. Check with the client to make sure the glasses are positioned comfortably.		
Removal of Eyeglasses: 1. Grasp the eyeglasses by the corners of the frames.		
2. Pull the glasses down along the bridge of the nose until the earpieces clear the tops of the ears.		
3. When the earpieces have cleared the tops of the ears, pull the glasses straight out away from the face.		
4. Fold the earpieces down.		
5. Place in an eyeglass case or in a safe place with the lens turned up.		

The student has satisfactorily completed the procedure "PLACE AND REMOVE EYEGLASSES" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 3: Dressing and Undressing

Skill Sheet

ASSIST A CLIENT TO DRESS

Student Name ________________________________ Date ______________

EQUIPMENT:

1. Complete outfit, outer wear and underwear
2. Shoes
3. Appropriate accessories
4. Adaptive devices, if applicable
5. Linen hamper or bag

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet the client.		
3. Identify self.		
4. Explain what you are going to do.		
5. Confer with the client to decide articles of clothing to be worn.		
6. Assemble necessary clothing and adaptive devices.		
7. Provide privacy.		
8. Assist the client in removing clothing currently being worn.		
9. Brassiere a. Place around the chest with fasteners in front.		
b. Fasten the bra.		
c. If the bra is a back-hook bra, shift it so fasteners are in back.		
d. Have client slip arms through the shoulder straps.		
e. Adjust cups to enclose breasts or assist the client to do so.		
10. Undershirt/slip/dress/shirt/sweater (over the head) a. Have client place arms into appropriate holes or assist the client to do so.		
b. Assist or have client put head into appropriate opening.		

c. Pull garment down into place over the client's shoulders, smoothing it in place down the client's back.		
11. Stockings/socks a. Roll the stocking/sock down to the toes.		
b. Support the client's ankle and slip the rolled stocking/sock over the toes.		
c. Smooth the stocking/sock over the heel, making sure there are no wrinkles.		
d. With one arm on each side of the client's leg, pull the stocking/sock up over the leg.		
e. Complete the same procedure with the other stocking/sock.		
12. Underpants/slacks/pants a. Place both feet through the openings for the legs.		
b. Slide the garment up as far as the client's position allows.		
c. If the client is lying down and can raise the hips, have him or her do so and pull the garment up over the hips. If the client is unable to lift the hips, turn the client first to one side then the other while pulling the garment up on each side.		
d. If the client can stand, he or she should do so with the garment pulled into place over the hips.		
e. Fasten the garment if necessary. If a male client has a catheter, leave the fly of the slacks unzipped to allow the tubing to pass through, and then pin the fly closed.		
13. Shoes a. Loosen laces and pull tongue of the shoes forward and up.		
b. Support the client's ankle while sliding the shoe onto the toes.		
c. With your hand on the bottom of the shoe to provide pressure, ease the shoe onto the heel. Using a shoehorn will ease the procedure for tight, supportive shoes.		
d. Have the client stand down on the shoe to force the foot completely into position.		
e. Tie shoelaces if needed.		
14. Dress/shirt that buttons down the front a. Place the weakest arm in a sleeve first.		
b. Bring the shirt around the back of the client.		

c. The remaining arm can either be lifted over the head to be placed in the armhole or held down and to the side with the arm bent back at the elbow.		
d. Assist with buttons or zippers as needed.		
15. Assist the client to put on accessories, such as suspenders, belts, scarves, or jewelry.		
16. Collect removed garments and put them in the appropriate receptacle. Put clean clothing in the closet or dresser and soiled linen and dirty clothing in a hamper.		
17. Make the client comfortable in an acceptable position or assist to the desired activity.		
18. Wash your hands.		
19. Record any pertinent observations and report unusual occurrences to the supervisor.		

The student has satisfactorily completed the procedure "ASSIST A CLIENT TO DRESS" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 3: Dressing and Undressing

Skill Sheet

ASSIST A CLIENT TO UNDRESS

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Hospital gown, or robe

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet the client.		
3. Identify self.		
4. Explain what you are going to do.		
5. Determine appropriate clothing to be put on after current garments are removed.		
6. Assemble necessary articles of clothing and adaptive devices.		
7. Provide privacy.		
8. Assist the client to sit on the side of the bed if strength permits or to lie down if he or she is feeling weak.		
9. Remove shoes. a. Loosen shoelaces and pull tongue up and away from the foot.		
b. Support the ankle with one hand and place other hand around the heel of the shoe.		
c. Pull the shoe away from the heel.		
d. When the shoe is free of the heel, pull the shoe up and off toes.		
e. Place shoes in closet or underneath bed where the client will not trip over them.		
10. Remove stockings/socks. a. Roll stocking/sock down to the ankle.		
b. Support the ankle with one hand while pulling stocking/sock down over the heel with the other hand.		
c. Slide stocking/sock up over toes.		

11. Undershirt/slip/dress/shirt/sweater (over the head) a. Loosen all fastenings		
b. Grasp bottom of the garment at the back		
c. Pull the garment up to the back of the client's neck.		
d. Pull the garment over the client's head from the back to the front.		
e. Pull the garment down over the client's arms.		
12. Dress/shirt that buttons up the front a. Loosen all fastenings.		
b. Remove the garment from the stronger side by sliding the sleeve down the client's arm and toward the back of the body.		
c. Pull the garment across the back.		
d. Slide the garment off the weaker arm.		
13. Slacks/pants/underpants a. Loosen all fastenings.		
b. If the client is able, the garment should be slipped down the legs while the client is standing.		
c. If the client is unable to remain standing but can raise the hips from a lying position, the garment can be slipped down over the hips while the client raises up.		
d. If the client cannot raise hips from a lying position, roll the client to one side and slip the garment over that hip, then roll the client to the other side and repeat the procedure.		
e. Slide the garment down the client's legs and off the feet.		
14. Brassiere a. Unfasten bra.		
b. Slip straps down arms.		
c. Pull the garment away from body and the straps off the arms.		
15. Collect garments removed and place them in appropriate receptacles.		
16. Make the client comfortable.		
17. If the client has been undressed and put to bed for the night, place the call device within reach.		
18. Wash your hands.		
19. Record pertinent observations and report unusual occurrences to the supervisor.		

The student has satisfactorily completed the procedure "ASSIST A CLIENT TO UNDRESS" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 4: Bathing

Skill Sheet

GIVE A COMPLETE BED BATH

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bedpan or urinal
2. Bath blanket
3. Linen hamper or bag
4. Basin of warm water
5. Two bath towels, two wash cloths
6. Gloves
7. Soap, deodorant and lotion
8. Orangestick
9. Clean gown or clothes
10. Comb or brush
11. Cosmetics and/or personal toilet articles
12. Clean bed linens

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify yourself.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Wash hands.		
8. Put on gloves.		
9. Offer toileting.		
10. When client completes toileting; empty, clean, and put away equipment.		
11. If client uses toileting facilities, remove and appropriately dispose of gloves, wash hands and put on clean gloves.		
12. Place client in supine position near side of bed where it is most comfortable for you to stand during procedure.		
13. Untuck bed linens.		
14. Remove bedspread and blanket; fold and place on a chair if reusing, otherwise place in linen bag.		

15. Cover top sheet with a bath blanket. Ask client to hold bath blanket in place; if client is unable to hold, tuck only the bath blanket under client's shoulders.		
16. Remove top sheet by pulling it out from under bath blanket and place it in linen bag at the bedside.		
17. Remove client's gown or pajamas.		
18. Place a face towel across client's chest.		
19. Fill bath basin 2/3 full of warm water.		
20. Wet washcloth and squeeze out excess water.		
21. Wash around eyes first. Start at inner corner and work out. Use different area of washcloth for each eye.		
22. Wash, rinse and dry face, ears, nose and mouth using face towel on client's chest.		
23. Wash, rinse and dry neck.		
24. Expose arm farthest from you.		
25. Place a bath towel lengthwise under arm from axilla to fingertips.		
26. Place basin of water on bed next to client's hand and immerse hand in water and wash.		
27. Remove basin.		
28. Wash and rinse shoulder, axilla, arm and hand.		
29. Dry shoulder, axilla, arm and hand.		
30. Repeat steps 24-29 with arm closest to you.		
31. Clean under fingernails, if dirty.		
32. Place a bath towel across chest, pulling bath blanket down from under towel and folding it to waist.		
33. Wash and rinse chest and breasts while lifting towel up from bottom.		
34. Dry skin thoroughly.		
35. Fold bath blanket to perineal area, keeping chest covered with a towel.		
36. Wash, rinse and dry abdomen.		
37. Draw bath blanket back up over towel and remove towel by pulling it out from under bath blanket.		

38. If bath water has not needed changing previously, it MUST be changed at this point.		
39. Expose farthest leg; flex or bend leg and place a towel lengthwise under leg up to the buttocks.		
40. Place bath towel lengthwise under leg from buttocks to toes.		
41. Wash and rinse leg and foot.		
42. Dry leg, foot and between the toes.		
43. Repeat steps 39-42 on leg nearest to you.		
44. Cover client with bath blanket.		
45. Toenail care may be done at this point.		
46. Place towel and washcloth in linen bag and get clean ones.		
47. Change bath water in basin.		
48. Ask or help client to turn on side with back facing you.		
49. Fold bath blanket over client's side to expose back and buttocks.		
50. Place a clean bath towel lengthwise parallel to client's back.		
51. Wash, rinse and dry back and buttocks.		
52. Remove and appropriately dispose of gloves.		
53. Wash hands.		
54. Give back rub using warmed lotion paying special attention to bony areas. If client has open lesions or draining wounds, put on a clean pair of gloves before giving back rub.		
55. If gloves were used to give back rub, remove and appropriately dispose of gloves.		
56. Wash hands.		
57. Put on clean gloves.		
58. Turn client on back.		
59. Place a clean towel under buttocks.		
60. If client is able, provide washcloth, soap and towel and instruct him or her to wash and dry perineal area.		
61. If client is unable, wash perineal area from front to back.		
62. If client did own perineal care, provide fresh water to wash hands.		

63. Collect dirty linen and place in an appropriate container.		
64. Remove and appropriately dispose of gloves.		
65. Wash hands.		
66. Apply warmed lotion as needed and deodorant. If client has open lesions or draining wounds, put on clean gloves before applying lotion or deodorant.		
67. Assist client to dress.		
68. Comb hair and apply cosmetics, if applicable.		
69. Remove, clean, and store equipment.		
70. Make client comfortable.		
71. Place call device within reach, if applicable.		
72. If gloves were used to apply lotion and deodorant, remove and appropriately dispose of gloves.		
73. Wash your hands.		
74. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "GIVE A COMPLETE BED BATH" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 4: Bathing

Skill Sheet

GIVE A TUB BATH

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Non-skid mats for tub and floor
2. Chair beside tub, wheelchair (if needed)
3. Bedpan or urinal
4. Robe and slippers
5. Bath towels, washcloths
6. Soap, deodorant, powder, lotion
7. Bath blanket
8. Clean gown or clothes
9. Personal toilet articles
10. Gloves
11. Disinfectant

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Check to see that bathtub and shower chair are clean.		
3. Place a nonskid mat in bathtub.		
4. Place a nonskid floor mat next to bathtub.		
5. Place a chair next to bathtub.		
6. Assemble necessary supplies and equipment.		
7. Identify and greet client.		
8. Identify yourself.		
9. Explain what you are going to do.		
10. Wash hands.		
11. Put on gloves.		
12. Offer toileting.		
13. When client completes toileting; empty, clean, and put away equipment.		
14. If client uses toileting facilities, remove and appropriately dispose of gloves, wash hands and put on clean gloves.		
15. Assist client to put on robe and slippers.		

16. Ambulate or transport client by whirlpool chair or wheelchair to tub room.		
17. Close tub drain and fill with water at least half-full.		
18. Check water temperature.		
19. Assist client to undress.		
20. Assist client into tub.		
21. Assist client in washing as needed. If client is unable to help, wash around eyes first, then wash face, ears and neck. After washing head, wash arms, hands, chest, abdomen and back. Rinse with warm water.		
22. Wash legs, feet and between toes. Rinse thoroughly with warm water.		
23. To wash perineal area, ask or assist client to turn slightly to one side. Rinse from front to back.		
24. Open tub drain and drain completely.		
25. Help client out of tub, cover with a bath blanket and assist to chair.		
26. Remove and appropriately dispose of gloves.		
27. Wash hands.		
28. If client has open wounds or drainage, put on a clean pair of gloves.		
29. Uncover client, one area at a time, and pat dry with a towel.		
30. Apply powder, lotion and deodorant, if applicable.		
31. Assist client to dress.		
32. If gloves were put on to dry and dress client, remove and appropriately dispose of them and wash hands..		
33. Return client to room and assist with any personal care such as shaving, nail care and hair care.		
34. Make client comfortable.		
35. Place call device within reach, if applicable.		
36. Return to tub room and put on gloves.		
37. Remove soiled articles and clean tub with disinfectant solution.		
38. Remove and appropriately dispose of gloves.		
39. Wash your hands.		
40. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "GIVE A TUB BATH" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 4: Bathing

Skill Sheet

GIVE A WHIRLPOOL TUB BATH

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Whirlpool chair or wheelchair
2. Bedpan or urinal
3. Robe and slippers
4. Bath towels, washcloths
5. Bath blanket
6. Soap, deodorant, powder, lotion
7. Clean gown or clothes
8. Personal toilet articles
9. Gloves
10. Disinfectant

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
NOTE: The following general procedure is applicable to all whirlpool tubs; however, each facility may have unique cleaning procedures or policies about giving baths that are specific to that facility. 1. Wash your hands.		
2. Check to see that whirlpool tub and chair are clean.		
3. Obtain chair from tub if it is a detachable, mobile model. If not, obtain a means of transporting client to whirlpool tub room.		
4. Assemble necessary supplies and equipment.		
5. Identify and greet client.		
6. Identify self.		
7. Explain what you are going to do.		
8. Wash hands.		
9. Put on gloves.		
10. Offer toileting.		
11. When client completes toileting; empty, clean, and put away equipment.		
12. If client uses toileting facilities, remove and appropriately dispose of gloves, wash hands and put on clean gloves.		
13. Assist client to put on robe and slippers.		
14. Ambulate or transport client to whirlpool tub room.		

15. Transfer client to whirlpool chair.		
16. Close tub drain and fill with water at least half-full.		
17. Assist client to undress.		
18. Secure safety straps and cover client with a bath blanket.		
19. If tub chair is detachable and has been used as a means of transport, engage seat on lift. Make sure pins are locked in lift arm slots and safety latches are closed.		
20. Put on gloves if they were removed earlier after toileting.		
21. Step on "up" pedal and lift chair to its maximum height.		
22. Turn chair on lift arm so client swings to side of tub.		
23. Facing client, lift client's feet over edge of tub.		
24. Turn chair so it is positioned directly over tub.		
25. Step on "down" pedal and let chair lower into water.		
26. Push whirlpool button. Water must be above level of jet port to function properly.		
27. Assist or bathe client's face and neck. Follow facility policy regarding use of soap in whirlpool tub.		
28. Assist or bathe client's arms, chest, abdomen, back, buttocks and perineal area.		
29. Step on "up" pedal, raising client until feet are level with whirlpool outlet.		
30. Dry upper body and drape a towel or bath blanket around shoulders.		
31. Bathe client's legs and feet.		
32. Raise lift to maximum height.		
33. Pull chair toward you, lifting client's feet over edge of tub.		
34. Dry feet and legs.		
35. Cover legs with a bath towel.		
36. Lower lift until client's feet are flat on floor.		
37. Remove and appropriately dispose of gloves.		
38. Wash hands.		
39. If client has open wounds or drainage, put on a clean pair of gloves.		

40. Apply powder, lotion, and deodorant, if applicable.		
41. Unfasten safety belt.		
42. Assist client to dress.		
43. If gloves were put on to dress client, remove, appropriately dispose of them and wash hands.		
44. Return the client to room and assist with any personal care such as shaving, nail care and hair care.		
45. Make client comfortable.		
46. Place call device within reach, if applicable.		
47. Return to whirlpool tub room and put on gloves.		
48. Remove soiled articles and clean tub according to facility guidelines.		
49. Remove and appropriately dispose of gloves.		
50. Wash your hands.		
51. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "GIVE A WHIRLPOOL TUB BATH" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 4: Bathing

Skill Sheet

GIVE A SHOWER BATH

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Non-skid mats for shower and floor
2. Chair beside shower, wheelchair (if needed)
3. Bedpan or urinal
4. Shower chair (if needed)
5. Shower cap (if needed)
6. Robe and slippers
7. Bath towels, washcloths
8. Bath blanket
9. Soap, deodorant, powder, lotion
10. Clean gown or clothes
11. Personal toilet articles
12. Gloves
13. Disinfectant

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Check to see that shower and shower chair are clean.		
3. Place a nonskid mat in shower stall if client will stand during shower.		
4. Assemble necessary supplies and equipment.		
5. Identify and greet client.		
6. Identify yourself.		
7. Explain what you are going to do.		
8. Wash hands.		
9. Put on gloves.		
10. Offer toileting.		
11. When client completes toileting; empty, clean, and put away equipment.		
12. If client uses toileting facilities, remove and appropriately dispose of gloves, wash hands and put on clean gloves.		
13. Assist client to put on robe and slippers.		
14. Ambulate or transport client to shower room using shower chair.		
15. Assists client into shower. If shower chair is used, lock wheels.		

16. Wash hands and put on gloves, if they were removed earlier after toileting.		
17. Assist client to undress.		
18. Cover client with a bath blanket until ready to start shower.		
19. Adjust spray temperature.		
20. Assist client in washing as needed. If client is unable to help, wash around eyes first, then wash face, ears and neck. After washing head, wash arms, hands, chest, abdomen and back. Rinse with warm water.		
21. Wash legs, feet and between toes. Rinse thoroughly with warm water.		
22. Wash and rinse perineal area front to back. If shower chair is used, wash female labia from front of chair and anal area from under chair.		
23. Wash between buttocks and rinse well from front to back.		
24. Turn off shower and cover client with bath blanket.		
25. Assist client out of shower.		
26. Remove and appropriately dispose of gloves.		
27. Wash hands.		
28. If client has open wounds or drainage, put on a clean pair of gloves.		
29. Uncover client, one area at a time, and pat dry with towel.		
30. Apply powder, lotion and deodorant, if applicable.		
31. Assist client to dress.		
32. If gloves were put on to dry and dress client, remove and appropriately dispose of them and wash hands.		
33. Return client to room and assist with any personal care such as shaving, nail care and hair care.		
34. Make client comfortable.		
35. Place call device within reach, if applicable.		
36. Return to shower room and put on gloves.		
37. Remove soiled articles and clean shower and shower chair with disinfectant solution.		
38. Remove and appropriately dispose of gloves.		
39. Wash your hands.		

40. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "GIVE A SHOWER BATH" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 5: Shaving

Skill Sheet

SHAVE A CLIENT WITH A SAFETY RAZOR

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Basin or sink of warm water
2. Safety razor
3. Mirror
4. Shaving cream
5. Washcloth and towel
6. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy		
7. Wash hands.		
8. Put on gloves.		
9. Position client in chair or sitting position in bed in well-lit area.		
10. Spread a towel under client's chin.		
11. Wet face with warm water.		
12. Apply a thick layer of shaving cream to face.		
13. Leave lather in place about 15-30 seconds.		
14. Using a downward stroke with razor, start under hairline in front of ear and work over cheek.		
15. Rinse razor often in water.		
16. Continue over chin, pulling skin tight to reach hair in depression under lip.		

17. Work upward on neck under chin, tipping head back to tighten skin of neck, and around to other side of face.		
18. Shave area around lips carefully. Ask client to draw upper lip down over teeth to tighten. Assist client if he or she cannot stretch skin tight.		
19. When finished shaving, wash face of any excess soap or lather.		
20. Pat face dry with towel.		
21. Apply aftershave lotion if client requests it.		
22. Remove towel from under chin.		
23. Place call device within reach, if applicable.		
24. Remove, clean and store equipment.		
25. Remove and appropriately dispose of gloves.		
26. Wash hands.		
27. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "SHAVE A CLIENT WITH A SAFETY RAZOR" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 5: Shaving

Skill Sheet

SHAVE A CLIENT WITH AN ELECTRIC RAZOR

Student Name ______________________________ Date ____________

EQUIPMENT:

1. Basin or sink of warm water
2. Face soap
3. Washcloth and towel
4. Electric razor
5. Mirror
6. Preshave and aftershave lotion
7. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Wash hands.		
8. Put on gloves.		
9. Sanitize razor head.		
10. Position client in chair or sitting position in bed in well-lit area.		
11. Spread a towel under client's chin.		
12. Wash face thoroughly with soap and water to remove dirt and oil.		
13. Apply preshave lotion if client requests it.		
14. Start shaving on one side of face below hairline in front of ear. Hold skin tight and use circular motions. Shave neck, around mouth, and over to other side of face and neck.		
15. When finished, apply aftershave lotion if client requests it.		

16. Remove towel from under chin.		
17. Sanitize razor head.		
18. Place call device within reach, if applicable.		
19. Remove, clean and store equipment.		
20. Remove and appropriately dispose of gloves.		
21. Wash hands.		
22. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "SHAVE A CLIENT WITH AN ELECTRIC RAZOR" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 6: Hair Care

Skill Sheet

COMB OR BRUSH HAIR

Student Name ______________________________ Date ____________

EQUIPMENT:

1. Comb or brush
2. Towel
3. Hair accessories
4. Mirror
5. Personal hair care products

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Wash hands.		
8. Place client's towel across pillow if client is in bed. For sitting client, place towel around shoulders.		
9. If client wears glasses, put them in a safe place.		
10. Remove any hairpins, combs, etc.		
11. Brush or comb hair gently using downward strokes, making sure all sections of hair are combed/brushed and all areas of scalp stimulated.		
12. Arrange hair to client's satisfaction.		
13. Let client use hand mirror to approve appearance or request adjustments.		
14. Roll up towel to trap hairs and debris inside roll.		
15. Place towel in a soiled linen receptacle.		
16. Make client comfortable.		

17. Place call device within reach, if applicable.		
18. Remove, clean and store equipment.		
19. Wash hands.		
20. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "COMB OR BRUSH HAIR" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 6: Hair Care

Skill Sheet

GIVE A TUB OR SHOWER SHAMPOO

Student Name ______________________ Date ____________

EQUIPMENT:

1. Washcloth, towels
2. Shampoo, conditioner and other hair care products
3. Comb and brush
4. Hair dryer, curlers, if applicable
5. Mirror
6. Gloves, if applicable

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Wash hands.		
8. Position client appropriately in tub or shower.		
9. Ask client to hold a folded washcloth/face towel over eyes.		
10. Apply water to hair until it is completely wet, using nozzle or pitcher.		
11. Apply small amount of shampoo.		
12. Work shampoo into lather, massaging well with fingertips.		
13. Rinse thoroughly, working from front to back and down length of hair.		
14. Repeat sudsing and rinsing, if necessary.		
15. Apply vinegar water, conditioner, or creme rinse as directed.		
16. Rinse thoroughly.		
17. Use towel to dry hair as much as possible.		

18. Encourage client to comb own hair to remove snarls and tangles, if able.		
19. Apply rollers or set hair if this is to be done.		
20. Dry hair with hair dryer.		
21. Remove curlers.		
22. Comb or brush hair into an attractive style.		
23. Let client use hand mirror to approve appearance or request adjustments.		
24. Make client comfortable.		
25. Place call device within reach, if applicable.		
26. Remove, clean and store equipment.		
27. Wash hands.		
28. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "GIVE A TUB OR SHOWER SHAMPOO" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 6: Hair Care

Skill Sheet

GIVE A BED SHAMPOO

Student Name ________________________________ Date ______________

EQUIPMENT:

1. Chair or footstool at bedside
2. Large basin or bucket
3. Pitcher of warm water
4. Washcloths, towels
5. Bath blanket
6. Waterproof bed protector
7. Shampoo trough or plastic sheet
8. Cotton balls
9. Shampoo, conditioner and other hair care products
10. Comb and brush
11. Hair dryer, curlers, if applicable
12. Mirror
13. Gloves, if applicable

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Wash hands.		
8. Raise bed to its highest horizontal position.		
9. Place chair or footstool at side of bed most comfortable for you to work from and near client's head; cover with a small towel.		
10. Set large basin or bucket on chair.		
11. Move client to side of bed nearest basin or bucket.		
12. Cover with bath blanket and fanfold top linens (refer to Lesson 11) to foot of bed without exposing client.		
13. Remove pillow and replace with a waterproof bed protector.		
14. Place one towel under client's head and one around shoulders to protect clothing/pajamas.		

15. Place shampoo trough or arrange plastic sheet under head to form drain into bucket.		
16. Put a cotton ball in each ear of client.		
17. Apply water to hair until it is completely wet, using a pitcher.		
18. Apply small amount of shampoo. Work shampoo into lather, massaging with fingertips.		
19. Rinse thoroughly, working from front to back and down length of hair.		
20. Repeat sudsing and rinsing, if necessary.		
21. Apply vinegar rinse, conditioner, or creme rinse as directed.		
22. Rinse thoroughly.		
23. Squeeze excess water from hair.		
24. Remove shampoo trough and place in bucket.		
25. Fold towel under head up around hair to contain wetness.		
26. Remove waterproof bed protector and replace pillow.		
27. Remove cotton balls from client's ears.		
28. Using another towel, dry hair.		
29. Encourage client to comb own hair to remove tangles, if able.		
30. Apply rollers or set hair if this is to be done.		
31. Dry hair with hair dryer.		
32. Remove curlers.		
33. Comb or brush hair into an attractive style.		
34. Let client use hand mirror to approve appearance or request adjustments.		
35. Make client comfortable.		
36. Place call device within reach, if applicable.		
37. Remove, clean and store equipment.		
38. Wash hands.		
39. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "GIVE A BED SHAMPOO" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 7: Oral Hygiene

Skill Sheet

ASSIST A CONSCIOUS CLIENT WITH ORAL HYGIENE

Student Name ____ Date ______________

EQUIPMENT:

1. Toothbrush, toothpaste
2. Cup with cool water, straw
3. Cup with diluted mouthwash
4. Emesis basin
5. Tissues, towel
6. Lip balm
7. Gloves, if applicable

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Wash hands.		
7. Put on gloves.		
8. Provide privacy.		
9. Dilute mouthwash (one part mouthwash to one part water) if client wishes.		
10. Assist client to bathroom or an upright sitting position.		
11. Pour water over toothbrush; instruct or assist client to put small amount of toothpaste on toothbrush.		
12. Instruct or assist client to brush horizontally along gum line.		
13. Instruct or assist client to brush teeth up and down from crown to edge on both front and back surfaces of teeth. NOTE: Client may need to spit out toothpaste once or several times during brushing. If so, allow client to spit into emesis basin or sink and repeat Step 10 as needed.		

14. Brush biting surfaces of molars with back-and-forth motion.		
15. Brush tongue gently from back to tip.		
16. Instruct or assist client to rinse mouth with water; hold emesis basin under client's chin with one hand if brushing in bed.		
17. Allow client to spit into emesis basin or sink; wipe lips with towel.		
18. Give client mouthwash (using a straw if needed); instruct client to swish it around and spit it out, cautioning client not to swallow mouthwash.		
19. Allow client to spit into emesis basin or sink; wipe lips with towel.		
20. Lubricate lips with lip balm.		
21. Allow client to wash and dry hands.		
22. Make client comfortable.		
23. Place call device within reach, if applicable.		
24. Remove, clean and store the equipment.		
25. Remove and appropriately dispose of gloves.		
26. Wash hands.		
27. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "ASSIST A CONSCIOUS CLIENT WITH ORAL HYGIENE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 7: Oral Hygiene

Skill Sheet

FLOSS TEETH

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Floss
2. Cup with cool water, straw
3. Emesis basin
4. Tissues, towel
5. Lip balm
6. Gloves, if applicable

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Wash hands.		
7. Put on gloves.		
8. Provide privacy.		
9. Assist client to bathroom or an upright sitting position.		
10. Break off an 18-inch piece of floss.		
11. Hold floss between middle finger of each hand. Wrap ends of floss around first two fingers of each hand and anchor with thumbs.		
12. Stretch floss between hands.		
13. Insert floss between back molars on one side of mouth and work back and forth.		
14. Move toward front of mouth and around to other side, flossing between each tooth on both upper and lower teeth. Use different section of floss after every second tooth.		

15. Allow or assist client to rinse mouth with water; hold emesis basin under client's chin with one hand if flossing in bed.		
16. Allow client to spit into emesis basin or sink; wipe lips with towel.		
17. Lubricate lips with lip balm.		
18. Allow client to wash and dry hands.		
19. Make client comfortable.		
20. Place call device within reach, if applicable.		
21. Remove, clean and store the equipment.		
22. Remove and appropriately dispose of gloves.		
23. Wash hands.		
24. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "FLOSS TEETH" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 7: Oral Hygiene

Skill Sheet

ADMINISTER ORAL HYGIENE TO A HELPLESS OR UNCONSCIOUS CLIENT

Student Name ______________________________ Date ____________

EQUIPMENT:

1. **Toothbrush**
2. **Towel, washcloths**
3. **Tongue depressor or Toothetts™**
4. **Cup with diluted mouthwash**
5. **Emesis basin**
6. **Lip balm**
7. **Gloves**

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Wash hands.		
7. Put on gloves.		
8. Provide privacy.		
9. Move client to side of bed that is easiest for you to work from.		
10. Turn client's head toward you.		
11. Spread towel under client's chin.		
12. Moisten toothbrush with diluted mouthwash. Brush gum line and teeth in up-and-down motion on both sides.		
13. Holding washcloth over emesis basin, moisten with diluted mouthwash.		
14. Wipe teeth and gums with washcloth wrapped over tongue depressor.		
15. Wipe client's lips with towel.		

16. Apply lip balm to lips.		
17. Make client comfortable.		
18. Place call device within reach.		
19. Remove, clean and store equipment.		
20. Remove and appropriately dispose of gloves.		
21. Wash your hands.		
22. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "ADMINISTER ORAL HYGIENE TO A HELPLESS OR UNCONSCIOUS CLIENT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 7: Oral Hygiene

Skill Sheet

PROVIDE DENTURE CARE

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Dentures
2. Toothbrush, denture cleanser
3. Cup of cool water, straw
4. Cup of diluted mouthwash
5. Emesis basin
6. Towels, washcloths
7. Clean denture cup
8. Lip balm
9. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Wash hands.		
7. Put on gloves.		
8. Provide privacy.		
9. Assist client to bathroom or an upright sitting position.		
10. Ask client to remove dentures, or remove them yourself. Remove lower dentures first by grasping them between thumb and forefinger and lifting up; then remove upper dentures by placing thumb in center of front of dentures and tip of index finger at back of plate. Simultaneously pull down with thumb while pushing up with forefinger to break suction of plate against roof of mouth.		
11. Place dentures in clean denture cup.		
12. Provide water or diluted mouthwash to rinse mouth of food particles.		
13. Allow client to spit into emesis basin or sink.		
14. Have client wipe mouth with towel or tissue.		

15. Fill clean sink half full of cool water or place clean washcloth on bottom of sink.		
16. Brush dentures thoroughly using toothbrush and denture cleanser.		
17. Rinse dentures with cool water and place them in clean cup.		
18. If client wants to wear dentures, replace in mouth (upper plate first).		
19. If client is not going to wear dentures, store in clean denture cup filled with appropriate solution.		
20. Apply lip balm to lips.		
21. Allow client to wash and dry hands.		
22. Make client comfortable.		
23. Place call device within reach, if applicable.		
24. Remove, clean and store equipment.		
25. Remove and appropriately dispose of gloves.		
26. Wash hands.		
27. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "PROVIDE DENTURE CARE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 8: Nail Care

Skill Sheet

GIVE FINGERNAIL CARE

Student Name ______________________________ Date ____________

EQUIPMENT:

1. Disposal bed protector
2. Towels, washcloth
3. Basin with warm, soapy water
4. Orange stick, nail clippers, nail file or emery board
5. Lotion
6. Gloves, if applicable

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary supplies and equipment. NOTE: Equipment should include a supplementary light, if necessary, to provide a well-lit working area.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Wash hands.		
7. Put on gloves, if appropriate.		
8. a. If client is in bed, raise backrest. Place disposable bed protector under client's hands. Place towel on top of bed protector.		
b. If client is in a chair, lower overbed table; place table in front of client with disposable bed protector on top. Place towel on top of bed protector.		
9. Place basin of warm, soapy water (approximately 105° Fahrenheit) on towel.		
10. Soak client's fingers in warm, soapy water for five minutes. Either soak one hand at a time or both together.		
11. Rinse hands with clear, warm water and dry with towel.		
12. Remove basin from in front of client.		

13. Place towel under client's dried hands.		
14. Gently remove dirt from around and under each fingernail with orange stick. Use paper towel to clean orange stick.		
15. Trim nails (if needed) straight across.		
16. Shape and smooth nails with emery board.		
17. Repeat steps 14-16 on other hand.		
18. Have client exercise hands by alternately stretching them and making a fist.		
19. Massage lotion into client's hands.		
20. Make client comfortable.		
21. Place call device within reach, if applicable.		
22. Remove, clean and store the equipment.		
23. Remove and appropriately dispose of gloves (if being worn).		
24. Wash hands.		
25. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "GIVE FINGERNAIL CARE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 8: Nail Care

Skill Sheet

GIVE TOENAIL CARE

Student Name ______________________________ Date ____________

EQUIPMENT:

1. Disposal bed protector or bathmat
2. Towels, washcloth
3. Basin with warm, soapy water
4. Orange stick, nail clippers
5. Lotion
6. Gloves, if applicable

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands		
2. Assemble necessary supplies and equipment. NOTE: Equipment should include a supplementary light, if necessary, to provide a well-lit working area.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Wash hands.		
7. Put on gloves, if appropriate.		
8. a. If client is in bed, raise bed backrest to a sitting position. Place disposable bed protector under client's feet. Place towel on top of bed protector.		
b. If client is in a chair, place a bath mat on the floor under client's feet.		
9. Place basin of warm water on towel/bath mat.		
10. Assist client in placing foot in basin if in bed or both feet in basin if in chair.		
11. Soak client's foot/feet to soften the nails.		
12. Wash foot/feet with soap and water.		

13. Rinse and dry foot/feet.		
14. Gently clean toenails with orange stick.		
15. If toenails are long and need trimming, report to supervisor. If facility policy allows, trim nails straight across top of toe; be sure nail does not extend beyond toe.		
16. Massage lotion into client's foot. NOTE: Repeat steps 10-16 for other foot if client is in bed.		
17. Make client comfortable.		
18. Place call device within reach, if applicable.		
19. Remove, clean and store the equipment.		
20. Remove and appropriately dispose of gloves (if being worn).		
21. Wash hands.		
22. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "GIVE TOENAIL CARE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion) ______________________

Date ______________

Lesson 9: Perineal Care

Skill Sheet

GIVE PERINEAL CARE TO A FEMALE CLIENT

Student Name ______________________________ Date ______________

EQUIPMENT:

1. **Waterproof bed protector**
2. **Bath blanket**
3. **Basin with warm water**
4. **Towels, washcloths**
5. **Gloves**

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Wash hands.		
7. Put on gloves.		
8. Provide privacy.		
9. Place client in supine or side-lying position.		
10. Place bed protector under buttocks.		
11. Fill basin with warm water and bring it to bedside.		
12. Cover client with bath blanket and pull back top linens to end of bed.		
13. Fold bath blanket up to abdomen, exposing perineal area.		
14. Have client flex and separate knees.		
15. Gently wash inner area from front to back, using clean area of washcloth for each wipe.		
16. Work outward through inner labia, outer labia, and groin creases, washing gently from front to back.		

17. Rinse area well, starting with innermost area and proceeding outward.		
18. Wash and rinse anal area.		
19. Pat perineal area dry with towel.		
20. Remove disposable bed protector and bath blanket.		
21. Make client comfortable.		
22. Place call device within reach, if applicable.		
23. Remove, clean and store equipment.		
24. Remove and appropriately dispose of gloves.		
25. Wash hands.		
26. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "GIVE PERINEAL CARE TO A FEMALE CLIENT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 9: Perineal Care

Skill Sheet

GIVE PERINEAL CARE TO A MALE CLIENT

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Waterproof bed protector
2. Bath blanket
3. Basin with warm water
4. Towels, washcloths
5. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Wash hands.		
7. Put on gloves.		
8. Provide privacy.		
9. Place client in supine or side-lying position.		
10. Place bed protector under buttocks.		
11. Fill basin with warm water and bring it to bedside.		
12. Cover client with bath blanket, and pull back top linens to end of bed.		
13. Fold bath blanket up to abdomen, exposing perineal area. Pull bed spread up to thighs or cover thighs with towel.		
14. Grasp penis around shaft and lift up.		
15. Using circular motion, start at tip of penis and cleanse downward.		
16. Rinse and dry with towel. NOTE: If foreskin has been retracted, pull back over end of penis.		

17. Wash and rinse other skin areas between legs.		
18. Wash and rinse anal area.		
19. Pat perineal area dry with towel.		
20. Remove disposable bed protector and bath blanket.		
21. Make client comfortable.		
22. Place call device within reach, if applicable.		
23. Remove, clean and store equipment.		
24. Remove and appropriately dispose of gloves.		
25. Wash hands.		
26. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "GIVE PERINEAL CARE TO A MALE CLIENT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 9: Perineal Care

Skill Sheet

GIVE PERINEAL CARE TO A CLIENT WITH A CATHETER

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Waterproof bed protector
2. Bath blanket
3. Catheter with tubing and bag
4. Basin with warm water
5. Towels, washcloths
6. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Wash hands.		
7. Put on gloves.		
8. Provide privacy.		
9. Place client in supine position with legs apart.		
10. Place bed protector under buttocks.		
11. Cover client with bath blanket and pull back top linens to knees.		
12. Check catheter and drainage bag for leaks, kinks, level of fluid in bag, character of urine, and secure attachment to bed frame.		
13. Fold bath blanket up onto abdomen to expose perineal area.		
a. Separate labia of female client and gently wash around opening of urethra with soap and warm water.		
b. Gently pull back foreskin (if present) of male client and gently wash around opening of urethra with soap and warm water.		

14. Wash catheter tubing from opening of urethra outward four inches or farther if needed without pulling on catheter.		
15. Using fresh washcloth, continue washing and rinsing peri area according to steps of procedure for female or male client.		
16. Remove bed protector and bath blanket.		
17. Make client comfortable.		
18. Place call device within reach.		
19. Remove, clean and store the equipment.		
20. Remove and appropriately dispose of gloves.		
21. Wash hands.		
22. Record pertinent observations and report unusual occurrences to the supervisor.		

The student has satisfactorily completed the procedure "GIVE PERINEAL CARE TO A CLIENT WITH A CATHETER" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 10: Backrub and Skin Care

Skill Sheet

GIVE A BACKRUB

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bath towel
2. Lotion
3. Gloves, if applicable

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary supplies and equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Wash hands.		
7. Put on gloves, if applicable.		
8. Provide privacy.		
9. Assist client to move to side of bed from which it is easier for you to work. NOTE: Refer to Unit 6 for additional information on positioning clients.		
10. Turn client onto side or assist him or her into prone position.		
11. Place bath towel lengthwise close to client's back to protect bedding.		
12. Expose client's back from neck to where buttocks meets thighs.		
13. Wash, rinse, and dry back (if giving bed bath or if back is soiled).		
14. Warm lotion; apply to entire back.		
15. Using long, soothing strokes, start at base of spine and rub up center of back, around shoulders, and down sides of back and buttocks. Repeat four times.		
16. Rub entire back, including buttocks, with small circular motions.		

17. Repeat long strokes.		
18. Pat dry with towel to remove excess lotion.		
19. Make client comfortable.		
20. Adjust bed covers.		
21. Place call device within reach, if applicable.		
22. Remove, clean and store the equipment.		
23. Wash hands.		
24. Remove and appropriately dispose of gloves (if being worn).		
25. Record pertinent observations and report unusual occurrences to the supervisor.		

The student has satisfactorily completed the procedure "GIVE A BACKRUB" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 11: Bedmaking

Skill Sheet

MAKE AN OCCUPIED BED

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bed with complete linens and side rails
2. Pillows
3. Soiled linen receptacle
4. Clean linens: bottom and top sheets, cotton and plastic draw sheets, mattress pad and pillowcase

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Gather linens and place in order to be used.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Wash hands.		
8. Put on gloves.		
9. Raise bed to comfortable working position, with side rail opposite side you are working remaining up.		
10. Lower back and knee rest until bed is flat, if client's condition allows.		
11. Loosen top of bedding at foot of bed.		
12. Fold bedspread to foot of bed, remove by grasping center, and place on back of chair if it is to be reused.		
13. Remove blanket according to step 12, if applicable.		
14. Ask client to hold top sheet in place or tuck it under client's shoulders.		
15. Turn client to side of bed away from you, keeping pillow under head.		
16. Loosen bottom bedding, rolling linens to client's back.		

17. Remove and appropriately dispose of gloves.		
18. Raise bed rail and wash hands.		
19. Wash hands.		
20. On same side, lower bed rail.		
21. Place mattress pad on bed lengthwise with fold in center.		
22. Place bottom sheet lengthwise with fold in center and lower edge of sheet even with foot of mattress.		
23. Tuck sheet under head of mattress, miter corners, and tuck well under side of mattress.		
24. Fanfold bottom sheet and mattress pad close to client's back.		
25. Place plastic draw sheet or protective pad on middle ⅓ of mattress (if needed), and tuck in near side fanfolding rest to client's back.		
26. Center cotton draw sheet over plastic draw sheet or protective pad (if needed), and tuck in near side fanfolding rest to client's back.		
27. Raise bed side rail; assist client in rolling over linen and moving to clean side of bed.		
28. Move pillow, keeping it under client's head.		
29. Go to opposite side of bed; lower bed side rail.		
30. Pull through all bottom linen; remove and place in bag or soiled linen receptacle. NOTE: If linens are soiled with secretions, gloves should be worn to remove soiled linen, then the gloves are discarded and hands washed before clean linen is touched.		
31. Pull clean mattress pad toward edge of bed and tuck under mattress.		
32. Pull clean bottom sheet toward edge of bed. Tuck it under mattress at head of bed and make mitered corner.		
33. Tuck bottom sheet under mattress along side of bed.		
34. Pull plastic draw sheet or protective pad and cotton draw sheet; tighten, and tuck under mattress.		
35. Assist client to center of bed.		
36. Place top sheet over soiled top sheet; ask client to hold clean sheet or tuck clean sheet only under client's shoulders.		
37. Remove soiled top sheet by pulling it out from under clean sheet and place in soiled linen receptacle.		

38. If blanket is used, place over top sheet; placed bedspread over blanket even with top sheet.		
39. Make toe pleat in top linen at foot of bed by folding over two inches where client's feet are.		
40. Tuck sheet, blanket, and bedspread at foot of bed under mattress and miter corners on each side.		
41. Change pillowcase and place pillow under client's head.		
42. Lower bed, recess bed cranks, and put both side rails up, if applicable.		
43. Place call device within reach, if appropriate.		
44. Place bagged, dirty linen in appropriate receptacle.		
45. Wash hands.		

The student has satisfactorily completed the procedure "MAKE AN OCCUPIED BED" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 11: Bedmaking

Skill Sheet

MAKE AN UNOCCUPIED BED

Student Name ________________________________ Date ______________

EQUIPMENT:

1. Bed with complete linens
2. Pillow
3. Soiled linen receptacle
4. Clean linens: bottom and top sheets, cotton and plastic draw sheets, mattress pad and pillowcase

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Gather linens and place in order to be used.		
3. Identify and greet client, (if client is in room).		
4. Identify self.		
5. Explain what you are going to do.		
6. Wash hands.		
7. Put on gloves.		
8. Position bed flat, raised to comfortable working height, and lower bed rails. NOTE: This step will not be possible if bed is standard piece of furniture.		
9. Strip pillowcase off pillow and place pillow out of way.		
10. Strip bed and place linen in soiled linen receptacle.		
11. Wash and dry mattress, if soiled.		
12. Remove and appropriately dispose of gloves.		
13. Wash hands.		
14. Place mattress pad on bed and pull smooth.		

15. Unfold bottom sheet on bed to full length, with bottom hem at bottom edge of mattress. NOTE: For fitted sheets, both corners should be secured onto mattress.		
16. Tuck bottom sheet under head of mattress and miter corners.		
17. Tuck in bottom sheet along side of bed, working from head to foot.		
18. Place plastic draw sheet or protective pad on middle ⅓ of mattress (if needed); tuck in near side only.		
19. Center cotton draw sheet over plastic draw sheet or protective pad (if needed) and tuck in near side.		
20. Place top sheet, halved, on full length of bed, with hem at edge of head end of mattress.		
21. Unfold top sheet.		
22. Place blanket over top sheet centered on bed and about eight (8) inches down from edge of top sheet.		
23. Place bedspread (centered) over top sheet and blanket, leaving enough bedspread to cover pillow at top edge.		
24. At foot of bed, miter corners of bottom sheet only and tuck under foot of bed.		
25. Gather one side of pillowcase from open end to seamed end.		
26. Grasping seamed end of case, allow gathers to fall back over your wrist.		
27. Grasp edge of pillow through pillowcase and, holding securely, work gathered pillowcase down over pillow.		
28. Place pillow on near half of bed with open end of pillowcase away from doorway.		
29. Going to other side of bed, fold back each piece of linen.		
30. Pull mattress pad smooth and tuck under mattress from head to foot.		
31. Pull bottom sheet tight (or if using fitted sheet, pull corners down over mattress); tuck under head of mattress; miter corner; tuck in remainder of sheet from head to foot.		
32. Tighten plastic draw sheet or protective pad; tuck in middle first, then top ⅓, and finally bottom ⅓.		
33. Repeat step 32 with cotton draw sheet.		

34. Pull top sheet, blanket, and bedspread straight; tuck under foot end of mattress.		
35. Miter corners of top sheet, blanket and bedspread together; allow sides to hang free.		
36. Place pillow in center of head of bed; pull bedspread over if bed is to be closed or fanfold all top linens to foot of bed if bed is to be open.		
37. Lower bed and recess bed cranks, if applicable.		
38. Raise bed rail on side away from entry.		
39. Place call device within reach, if appropriate.		

The student has satisfactorily completed the procedure "MAKE AN UNOCCUPIED BED" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Written Unit Evaluation

Student Name ________________________________ Date __________________

Circle the letter that corresponds to the best answer.

1. Where is the greatest amount of support given when a client is moved?

    a. To the moving part
    b. To the body part which is "dead weight"
    c. To the heaviest part of the body
    d. To the body part which is out of alignment

2. When a nurse assistant has never worked with a group of clients before, in which of these circumstances should the nurse assistant obtain help in attempting to move one of the clients?

    a. When a client has contractures of both elbows and uses a cane for ambulation
    b. When the client appears heavy and does not appear to be able to assist in any way
    c. When the client has multiple aids for ambulation: a trapeze, a sliding board, a sling for the left arm and a brace for the left leg
    d. When a client is extremely slow and is unable to put on their own shoes

3. When a client with a weak or non-functional side is transferred from the bed to a chair, which of the following indicates the correct placement for the chair?

    a. At the head of the bed against the wall on either side of the bed
    b. At a ninety degree angle with the bed on the client's non-functional side
    c. With the back to the bed on either side of the bed
    d. With the arms parallel to the bed on the client's functional side

4. What should the nurse assistant do to prevent the client from becoming light-headed and dizzy during transfers?

    a. Have the client change positions slowly
    b. Keep the client in alignment
    c. Use a gait belt to do the transfer
    d. Determine if help is needed before beginning the transfer

5. How can proper positioning of the legs be determined when the client is sitting in a chair?

    a. The chair fits snugly against the back of the knees and lower legs
    b. The client is able to cross his or her legs at the ankles
    c. The hips and buttocks fit against the back of the chair
    d. Two or three fingers can be inserted between the back of the knees and the chair

6. When two nurse assistants are repositioning a client in a chair, besides holding onto a gait belt at the client's back with one hand, each nurse assistant should place their other hand:

   a. Under the client's armpit.
   b. Under the client's buttock.
   c. Under the client's thigh.
   d. Under the client's forearm.

7. The purpose of a cane is to:

   a. Support body weight.
   b. Help maintain balance.
   c. Guide the client during ambulation.
   d. Improve mobility.

8. If a client starts to fall during ambulation and cannot be stabilized with the gait belt, what should the nurse assistant do?

   a. Let go of the gait belt and grab the client's shoulders and hips
   b. Pull the client close and slide the client down to the floor
   c. Hold the client up by the gait belt and call for assistance
   d. Maneuver the client toward the closest stable object and step back out of the way

9. If the client is unable to help in any way, which type of range of motion exercises should be done?

   a. Passive range of motion
   b. Active-assistive range of motion
   c. Active range of motion
   d. Resistive range of motion

10. Which of these indicates a correct role for the nurse assistant in active range of motion exercises?

    a. Provide pressure against which the client moves
    b. Give slow and smooth repetitive movement to each joint
    c. Support the joint above and below the movement
    d. Observe the exercise and give encouragment

11. Moving a helpless client to the head of a bed requires:

    a. One nurse assistant and a lift sheet.
    b. Two nurse assistants and a lift sheet.
    c. Three nurse assistants and a lift sheet.
    d. Four nurse assistants if the client has an IV or tubing.

12. Client transfers should only be performed by the home health aide when:

    a. The client requests to be moved.
    b. There is help from a primary caregiver
    c. The aide is strong enough and the client can assist.
    d. A heavy client needs to be repositioned.

13. A lift/draw sheet can be used by three nurse assistants to:

    a. Transfer a client to a gurney.
    b. Turn a client on his or her side.
    c. Transfer a client to a wheelchair and back again.
    d. Raise a client while making his or her bed.

14. Raising a client's head and shoulders:

    a. Requires two health care workers.
    b. Requires a mechanical lift.
    c. Should be done only at meal time.
    d. Can be done with the client's assistance.

15. When moving or assisting a client to the head of a bed the nurse assistant should:

    a. Unlock the wheels on the bed so it moves easier.
    b. Slide one arm under the client's shoulders and the other under the buttocks.
    c. Slide one arm under the client's shoulders and the other under the thighs.
    d. Remove the pillow and lay it on the floor, out of the way.

16. To help a stroke victim maintain balance prior to transfers or ambulation:

    a. Place a client's non-functional arm in a sling.
    b. Observe the client's blood pressure and heart rate.
    c. Lower the side rails on the client's bed.
    d. Prop the client's head up with a pillow.

17. How many people are needed to safely manage a client when using a mechanical lift?

    a. One
    b. Two
    c. Three
    d. Four if the client has an IV or tubing.

18. Ambulation promotes:

    a. Circulation to the client's arms.
    b. Bowel expansion.
    c. Better rescue services in a community.
    d. Muscle tone in the leg and back muscles.

19. A two-person sitting transfer should be performed when:

    a. Moving a non-dependent client from a wheelchair to a bed.
    b. Moving a dependent client from a bed to a gurney.
    c. Moving a client between two surfaces of unequal height.
    d. Moving a client between two surfaces of equal height.

20. To help a client into the prone position the nurse assistant must begin by:

    a. Extending the client's arms over his or her head.
    b. Placing the client in the side-lying position.
    c. Requesting assistance from another caregiver.
    d. Crossing the client's arms across his or her chest.

21. A cane is held:

    a. On the weak side.
    b. On the strong side.
    c. To the front of the weak side.
    d. To back of the strong side.

22. Muscles are more flexible when range of motion exercises are done

    a. After eating.
    b. Prior to ambulating.
    c. Shortly after a warm bath.
    d. First thing in the morning.

23. Joints are exercised during range of motion:

    a. To the point of pain.
    b. To the point of discomfort.
    c. The average number of repetitions.
    d. The specified number of repetitions.

Match the words in Column A with the correct definition/description from Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

COLUMN A

____ 24. Alignment

____ 25. Footboard

____ 26. Gait belt

____ 27. Ambulation

____ 28. Brace

____ 29. Range of motion

____ 30. Atrophy

____ 31. Contractures

____ 32. Trapeze

COLUMN B

a. Supports weakened muscles or joints

b. Deformities of joints

c. Prevents footdrop

d. Walking

e. Props the client in different positions

f. Muscle shrinking and losing strength

g. Triangular grab bar which fits on bed above client

h. Moving the joints through their normal pattern of movement

i. Body parts positioned for comfort and function

j. Inability to move as desired

k. Assists in lifting, maneuvering and holding on to client

l. Mechanical lift used for transfers

Match the types of transfers in Column A with their correct description from Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B are each used once.

COLUMN A

____ 33. Independent transfer

____ 34. Dependent transfer

____ 35. Active-assisted transfer

____ 36. Passive-assisted transfer

COLUMN B

a. Requires assistance of at least one other person

b. Client is unable to assist in any way

c. Client does everything with no help

d. Client assists to some degree

Lesson 1: Moving and Positioning the Client

Skill Sheet

ASSIST WITH OR RAISE CLIENT'S HEAD AND SHOULDERS

Student Name ______________________________ Date ________________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Pillow

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client.		
3. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Raise bed to a comfortable working height.		
7. Lock wheels on bed.		
8. Make certain far side rail is raised.		
9. Lower side rail near you.		
10. Face the head of the bed with your feet shoulder width apart, one foot slightly ahead of the other.		
11. Instruct client to put near arm under your near arm and behind your shoulders with hand on your shoulder. NOTE: If you are standing at the client's right side, his or her right hand will be on your right shoulder. If you are on his or her left, the client's left hand will be on your left shoulder.		
12. Put your arm under the client's arm with your hand on his or her shoulder. Thus, you will lock arms with the client.		
13. Put your other arm under the client's neck and shoulders and help him or her to raise up.		
14. While keeping your arm locked with the client's, use your other arm to adjust the pillow.		

15. Ease the client down with the locked arm while supporting client's neck and shoulders with other arm.		
16. Make certain client is in good body alignment.		
17. Lower bed to lowest position.		
18. Raise side rail near you if ordered.		
19. Make the client comfortable.		
20. Place call device within reach.		
21. Wash your hands.		

The student has satisfactorily completed the procedure "ASSIST WITH OR RAISE CLIENT'S HEAD AND SHOULDERS" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 1: Moving and Positioning the Client

Skill Sheet

MOVE HELPLESS CLIENT TO THE HEAD OF THE BED

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bed with side rails
2. Lift sheet/folded bed sheet
3. Pillow

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Ask another nurse assistant to work with you.		
2. Wash your hands.		
3. Identify and greet client.		
4. Identify self and other nurse assistant.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Raise bed to a comfortable working height.		
8. Lock wheels on bed.		
9. Lower backrest.		
10. Lower side rails.		
11. If the client has any tubing that is pinned to the bedding, unfasten the tubing so that it will move freely with the client.		
12. Move pillow to headboard so client does not hit head when moving up.		
13. Nurse assistants should stand on opposite sides of the bed.		
14. Position a lift sheet/folded regular sheet under shoulders and hip area, if one is not already present.		
15. Each nurse assistant should roll edges of the sheet toward the client's body and grasp the rolled sheet with his or her hands at the client's shoulders and at the mid-hip area.		
16. Point your feet in the direction that you are moving the client; bend knees, keep back straight.		

17. On the count of three, each nurse assistant lifts the client up off the surface of the bed and toward the head of the bed while shifting weight from the back foot to the front foot. Lower client to bed surface.		
18. Replace pillow.		
19. Adjust backrest for comfort.		
20. Lower bed to lowest position.		
21. Raise side rails if ordered.		
22. Make the client comfortable.		
23. Place call device within reach.		
24. Fasten tubing if unpinned while moving the client.		
25. Adjust bedding.		
26. Wash your hands.		

The student has satisfactorily completed the procedure "MOVE HELPLESS CLIENT TO THE HEAD OF THE BED" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 1: Moving and Positioning the Client

Skill Sheet

MOVE OR ASSIST CLIENT TO THE HEAD OF THE BED

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Pillow

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client.		
3. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Raise bed to a comfortable working height.		
7. Lock wheels on bed.		
8. Lower backrest.		
9. Lower side rail on the side you are working.		
10. If the client has any tubing that is pinned to the bedding, unfasten the tubing so that it will move freely with the client.		
11. Move pillow to headboard so client does not hit head when moving up.		
12. Help client bend knees and press feet firmly against the mattress.		
13. If client is able, have him or her grasp head of bed or trapeze bar (if present above the bed), otherwise the client should cross arms over his or her chest.		
14. Slide one arm under the client's shoulders and the other under the thighs.		
15. Stand facing head of the bed with your feet shoulder width apart. Front foot should be slightly ahead of the back foot.		

16. On the count of three, have the client push with feet and you shift your weight from your back leg to your front leg as you slide the client up in the bed.		
17. Replace pillow.		
18. Adjust backrest for comfort.		
19. Lower bed to lowest position.		
20. Raise side rails if ordered.		
21. Make the client comfortable.		
22. Place call device within reach.		
23. Fasten tubing if unpinned before moving the client.		
24. Adjust bedding.		
25. Wash your hands.		

The student has satisfactorily completed the procedure "MOVE OR ASSIST CLIENT TO THE HEAD OF THE BED" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion) Date

Lesson 1: Moving and Positioning the Client

Skill Sheet

MOVE CLIENT TO ONE SIDE OF THE BED

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bed with side rails if appropriate

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client.		
3. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Raise bed to a comfortable working height.		
7. Lock wheels on bed.		
8. Lower backrest.		
9. Lower side rail on the side you are working.		
10. If the client has any tubing and it is pinned to the bedding, unfasten the tubing so that it will move freely with the client.		
11. Remove pillow and loosen top sheets without exposing the client.		
12. Stand on the side of the bed toward which you intend to move client.		
13. Position front leg with one knee against the bed and the other leg (back) approximately two feet behind the front leg.		
14. Slide both arms under the client's back to his or her far shoulder, then slide the client's shoulders toward you on your arms by shifting your body weight from the front leg to the back leg. NOTE: Keep your knees bent and your back straight as you slide the client.		
15. Slide both your arms as far as you can under the client's buttocks and slide his or her buttocks toward you.		

16. Place both your arms under the client's feet and slide them toward you on your arms.		
17. Replace pillow.		
18. Adjust backrest for comfort.		
19. Lower bed to lowest position.		
20. Raise side rails if ordered.		
21. Make the client comfortable.		
22. Place call device within reach.		
23. Fasten tubing if unpinned before moving client.		
24. Adjust bedding.		
25. Wash your hands.		

The student has satisfactorily completed the procedure "MOVE CLIENT TO ONE SIDE OF THE BED" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 1: Moving and Positioning the Client

Skill Sheet

TURN CLIENT TO SIDE

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Four pillows - additional blankets/towels as needed
3. Handroll or wash cloth

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client.		
3. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Raise bed to a comfortable working height.		
7. Lock wheels on bed.		
8. Lower backrest.		
9. Lower side rail on side from which you are working.		
10. If the client has any tubing that is pinned to the bedding, unfasten the tubing so that it will move freely with the client.		
11. Remove pillow and loosen the top sheets without exposing the client.		
12. Check to see that the client has ample space to turn without falling off the edge of the bed. If not, have client move over more in bed, or move the client to the opposite side of the bed from which the client is being turned.		
13. Cross the client's arms over his or her chest.		
14. **Turning client toward you:** a. Cross the leg furthest from you over the leg closest to you.		
b. Reach across the client and put one hand behind far shoulder.		

c. Place your other hand behind far hip, gently roll the client toward you.		
Turning client away from you: a. Cross the leg closest to you over the leg furthest from you.		
b. Place one hand on the client's shoulder that is near you.		
c. Put your other hand under client's buttocks and turn gently onto side, facing away from you.		
15. Fold a pillow lengthwise and place it against the client's back for support.		
16. Support the client's head with the palm of one hand and slide a pillow under head and neck with the other hand.		
17. Position client's knees slightly flexed, upper leg more flexed than the lower leg. Support upper leg by placing on a pillow.		
18. Support upper arm by placing on a pillow.		
19. For client with a nonfunctional side, place handroll or rolled washcloth in the client's hand and position thumb in opposition to fingers.		
20. Lower bed to lowest position.		
21. Raise side rails if ordered.		
22. Make the client comfortable.		
23. Place call device within reach.		
24. Fasten tubing if unpinned before moving the client.		
25. Adjust bedding.		
26. Wash your hands.		

The student has satisfactorily completed the procedure "TURN CLIENT TO SIDE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 1: Moving and Positioning the Client

Skill Sheet

TURN CLIENT TO PRONE POSITION

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Two small, firm pillows or folded blankets
3. Handroll or washcloth
4. Additional pillows/blankets/towels as needed

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client.		
3. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Raise bed to a comfortable working height.		
7. Lock wheels on bed.		
8. Lower backrest.		
9. Lower side rail on side from which you are working.		
10. If the client has any tubing that is pinned to the bedding, unfasten the tubing so that it will move freely with the client.		
11. Remove pillows and loosen top sheets without exposing the client.		
12. Move the client to side of bed where you are.		
13. Turn client to side.		
14. Again, move the client to side of bed you are on, keeping the client on his or her side.		
15. Position lower arm close to side.		
16. Cross upper leg over lower leg.		
17. Roll the client onto his or her abdomen.		

18. Roll head to one side and place a small, firm pillow or folded blanket under the head. Do not use a full pillow as it may cause neck strain and interfere with breathing. CAUTION: Clients can smother if left unsupervised in prone position. A client should not be left in a prone position for an extended length of time, never more than 30 minutes, and many clients should not be left that long.		
19. Position arms: a. Arm opposite the side to which head is turned may be left at side, other arm bent at elbow, and forearm positioned alongside head. OR		
b. Both arms remain at sides, slightly flexed at the elbows. OR		
c. Both arms bent at elbows and forearms positioned alongside head.		
20. Place a small, firm pillow under the shoulder to which the head is turned.		
21. For female clients, place a small, firm pillow under the abdomen to prevent pressure on breasts.		
22. Extend feet over the end of mattress or slightly elevate feet off the mattress by flexing knees and placing a pillow under lower legs.		
23. For client with a nonfunctional side, place handroll or rolled washcloth in client's hand and position the thumb in opposition to fingers.		
24. Lower bed to lowest position.		
25. Raise side rails if ordered.		
26. Make the client comfortable.		
27. Place call device within reach.		
28. Fasten tubing if unpinned while moving the client.		
29. Adjust bedding.		
30. Wash your hands.		

The student has satisfactorily completed the procedure "TURN CLIENT TO PRONE POSITION" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 2: Transferring the Client

Skill Sheet

TRANSFER CLIENT FROM BED TO CHAIR

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Wheelchair or armchair
3. Bath blanket or protective pad
4. Gait belt
5. Pillows - as needed
6. Lap robe/blanket

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet the client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Adjust bed height to low position.		
8. Lock wheels on bed.		
9. Raise head of bed to bring the client to a sitting position.		
10. Help the client to move over in bed. He or she should be within five or six inches of the edge of the bed.		
11. Help in putting on socks and nonskid shoes.		
12. Position wheelchair on the client's strong side, if indicated, and brace the chair to prevent it from slipping.		
13. Place the chair parallel to or at a 45° angle to the bed.		
14. Lock the wheels of the chair.		
15. Cover wheelchair with bath blanket and/or protective pad.		
16. If possible, remove the armrest on the side next to the bed. Also, raise and remove footrests.		
17. Position your body facing foot of bed.		

18. Put one forearm under client's shoulders and other behind the knees.		
19. Bend your knees, keep your back straight, and stand with feet shoulder width apart.		
20. Straighten your hips and knees while shifting weight from your front foot to your back foot. At the same time, lift the client's head-neck with one arm while pulling the legs over the side of bed with other arm.		
21. Apply gait belt.		
22. Allow the client time for his or her circulation to adjust to being in a sitting position before you continue. Help the client in maintaining a sitting position as needed.		
23. **If the client can help:** a. Place your hands underneath the belt along the client's side with palms up.		
b. Instruct the client to stand on the count of three.		
c. Assist the client to stand and support a weak leg with your knee, if indicated.		
d. Instruct the client to reach with his or her strong hand and grasp for the far armrest of the chair.		
e. Assist the client to pivot toward his or her strong leg by turning your own body. Do not twist; turn your body as a unit.		
f. Gently help the client to sit by bending your knees while keeping your back straight.		
g. Position the weak arm and leg properly on the armrest and footrest. Use a pillow to support the weak arm.		
If the client cannot help: a. Stand directly in front of the client, grasp the back of the belt.		
b. Support the client's knees and feet with your knees and feet, either knee-to-knee or your knees on the sides of the client's knees, whatever is comfortable for you and the client.		
c. Have the client lean forward while sitting on the edge of the bed.		
d. On the count of three, have the client push up as much as possible while you hold onto the belt and pull him or her up by straightening your legs and hips.		
e. Pivot your entire body and the client's.		

f. Lower the client into the chair by bending at your knees and hips as the client sits.		
g. Adjust footrest for client; cover with a lap robe.		
h. Position pillow(s) to provide proper body alignment and joint support.		
24. Make the client comfortable.		
25. Place call device within reach.		
26. Wash your hands.		

The student has satisfactorily completed the procedure "TRANSFER CLIENT FROM BED TO CHAIR" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 2: Transferring the Client

Skill Sheet

TRANSFER CLIENT FROM CHAIR TO BED

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Wheelchair or armchair
3. Lap robe/blanket
4. Gait belt

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet the client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Adjust bed height to low position.		
8. Lock wheels on bed.		
9. Raise head of bed and fanfold bedclothes to end of bed. Make sure opposite side rail is raised.		
10. Position chair/wheelchair at side of bed, facing head of bed.		
11. Lock the wheels of the chair.		
12. Bring up footrests, placing client's feet on the floor.		
13. Remove lap robe/blanket.		
14. Remove safety restraint, if applicable.		
15. Apply gait belt.		
16. Stand in front of the client. Your feet should be about shoulder width apart.		
17. Place your hands underneath the belt. If the client is able, have him or her place hands on your shoulders.		

18. Assist the client to stand and support a weak leg with your knee, as indicated.		
19. Pivot your body and the client's body toward the bed.		
20. Slowly lower the client to sitting position on the bed by bending your knees while keeping your back straight.		
21. Remove gait belt.		
22. Position your body facing the foot of the bed. One foot should be in front of the other foot.		
23. Place one forearm on the client's shoulders and the other behind the client's knees.		
24. Swing or assist the client's legs onto the bed as you pivot the client's body back into a supine or lying position.		
25. Lower head of bed.		
26. Help move the client to center of bed.		
27. Remove slippers.		
28. Cover client, position pillows, and straighten bed clothes.		
29. Lower bed to lowest position.		
30. Raise side rails if ordered.		
31. Make the client comfortable.		
32. Place call device within reach.		
33. Wash your hands.		

The student has satisfactorily completed the procedure "TRANSFER CLIENT FROM CHAIR TO BED" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 2: Transferring the Client

Skill Sheet

TRANSFER CLIENT WITH MECHANICAL LIFT

Student Name ______________________________ Date ___ __________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Wheelchair
3. Mechanical lift
4. Lap robe/blanket

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Ask another nurse assistant to work with you.		
2. Wash your hands.		
3. Assemble necessary equipment.		
4. Identify and greet the client.		
5. Identify self and other nurse assistant.		
6. Explain what you are going to do.		
7. Provide privacy.		
8. Adjust bed height to low position.		
9. Lock wheels on bed.		
10. Position wheelchair next to bed. The back of the wheelchair should be in line with the headboard of the bed.		
11. Position the sling under the client by turning the client from side to side on the bed. Place the top of the sling at the shoulders and the bottom above the bend of the knee.		
12. Wheel the lift into place over the client. Put the lift's base beneath the bed.		
13. Lock the wheels of the lift.		
14. Lower the lift arm.		
15. Attach the sling to the mechanical lift. The open, sharp ends of the hooks should face away from the client.		
16. Have the client fold both arms across chest, if possible, or place in lap.		

17. Using the crank, lift the client until the buttocks are clear of the bed. Make sure the client is aligned in the sling and is securely suspended in a sitting position with legs dangling over the bottom of the sling.		
18. One caregiver should guide the client's legs over the edge of the bed while the other stabilizes the lift.		
19. Unlock the wheels of the lift and, with one person stabilizing the sling, move the lift away from the bed.		
20. The person stabilizing the sling guides the client toward the chair while the other person moves the lift toward the chair until the client is over the seat of the chair.		
21. Release the control knob slowly so that the client will gradually be lowered into the chair.		
22. Remove the hooks from the frame of the lift.		
23. Cover the client with a lap robe.		
24. Secure the client to the chair with safety restraint, if ordered.		
25. Make the client comfortable.		
26. Place call device within reach.		
27. Store the lift properly until time to transfer the client again.		
28. Wash your hands.		

The student has satisfactorily completed the procedure "TRANSFER CLIENT WITH MECHANICAL LIFT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 2: Transferring the Client

Skill Sheet

TRANSFER CLIENT FROM BED TO GURNEY

Student Name ________________________________ Date ______________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Gurney with pillow and sheet.
3. Lift sheet or folded sheet.

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Ask two nurse assistants to work with you.		
2. Wash your hands.		
3. Assemble necessary equipment.		
4. Identify and greet the client.		
5. Identify self and other nurse assistants.		
6. Explain what you are going to do.		
7. Provide privacy.		
8. Line up gurney so that it is parallel to the side of the bed.		
9. Raise bed to height of gurney.		
10. Lock or block wheels of all equipment.		
11. If the client has tubing that is pinned to the bedding, unfasten the tubing so that it will move freely with the client.		
12. Loosen top covers of bed.		
13. Remove all linen except top sheet.		
14. Put the client in the supine position with arms folded over chest or positioned close to body.		
15. Remove pillow.		
16. Two nurse assistants stand beside gurney and reach across it to grasp the lift sheet under the client.		
17. A third nurse assistant stands on the far side of the bed and grasps the lift sheet under the client.		

18. On the count of three, the nurse assistants slide (lifting the client slightly and supporting the head) the client from the bed to the gurney. Be careful not to pull on lines or tubing.		
19. Place pillow under the client's head.		
20. Raise side rails on gurney.		
21. Cover the client with a sheet.		
22. Fasten tubing to gurney.		
23. Unlock gurney wheels. The client is now ready for transport.		
24. Adjust bed linens to open position in preparation for the client's return if appropriate.		
25. Wash your hands.		

The student has satisfactorily completed the procedure "TRANSFER CLIENT FROM BED TO GURNEY" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 2: Transferring the Client

Skill Sheet

TRANSFER CLIENT USING A THREE-PERSON CARRY TRANSFER

Student Name ________________________________ Date ______________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Gurney with pillow and sheet

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Ask two nurse assistants to work with you.		
2. Wash your hands.		
3. Assemble necessary equipment.		
4. Identify and greet the client.		
5. Identify self and other nurse assistants.		
6. Explain what you are going to do.		
7. Provide privacy.		
8. Position bed and gurney at right angles if possible.		
9. Raise bed to height of gurney.		
10. Lock or block wheels of all equipment.		
11. If the client has tubing that is pinned to the bedding, unfasten the tubing so that it will move freely with the client.		
12. Three nurse assistants line up along the side of the bed. The tallest person should be at the client's head and gives the commands. NOTE: A fourth person is needed if the client has IVs or other tubing and equipment.		
13. The three nurse assistants slide their arms under the client.		
14. On the count of three, they slide the client to the edge of the bed.		
15. On the second command, the client is rolled toward the lifters' chests.		
16. On the third command, they walk to the gurney and use good body mechanics by bending knees to lay the client down.		

17. The nurse assistants carefully remove their arms from under the client.		
18. Position the client comfortably.		
19. Place pillow under the client's head.		
20. Raise side rails on the gurney.		
21. Cover the client with a sheet.		
22. Fasten tubing to gurney.		
23. Unlock gurney wheels. The client is now ready for transport.		
24. Adjust bed linens to open position in preparation for the client's return if appropriate.		
25. Wash your hands.		

The student has satisfactorily completed the procedure "TRANSFER CLIENT USING A THREE-PERSON CARRY TRANSFER" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 2: Transferring the Client

Skill Sheet

TRANSFER CLIENT USING A TWO-PERSON SITTING TRANSFER

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Wheelchair

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Ask another nurse assistant to work with you.		
2. Wash your hands.		
3. Assemble necessary equipment.		
4. Identify and greet the client.		
5. Identify self and other nurse assistant.		
6. Explain what you are going to do.		
7. Provide privacy.		
8. Adjust bed height to low position.		
9. Lock wheels on bed.		
10. Position wheelchair where transfer is to take place, lock the wheels and raise footrests.		
11. Raise head of bed to bring the client to a sitting position.		
12. Position the taller and stronger lifter behind the client's head. This person stands and reaches under the client's arms and grasps the client's crossed wrists.		
13. The other lifter stands in position by the side of the bed and reaches under the thighs and legs.		
14. On the count of three, the client is lifted up and out of the bed and lowered into the wheelchair by bending at the knees and hips.		
15. Adjust footrests for client; cover with a lap robe.		
16. Position pillow(s) to provide proper body alignment and joint support.		
17. Make the client comfortable.		
18. Wash your hands.		

The student has satisfactorily completed the procedure "TRANSFER CLIENT USING A TWO-PERSON TRANSFER" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion)

Date

Lesson 3: Ambulation

Skill Sheet

AMBULATE CLIENT WITH A GAIT BELT

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Gait belt
3. Hand rail, if available
4. Wheelchair or armchair

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet the client.		
3. Identify self.		
4. Explain what you are going to do.		
5. Make sure client has on appropriate attire for ambulation.		
6. Lower bed to lowest level.		
7. Assist the client to sit on edge of bed.		
8. Pause and allow the client to sit a few moments to regain balance.		
9. Assist the client in putting on nonskid shoes and socks.		
10. Put a gait belt around the client's waist.		
11. Stand in position of good body mechanics.		
12. Help the client to a standing position by grasping belt at the client's sides.		
13. Straighten your legs as you lift with the gait belt and the client pushes down with hands on the mattress.		
14. Pause to allow the client to regain balance by placing his or her hands on your forearms.		
15. Place one arm in front of the client's waist and the other hand in back under the gait belt. Walk with the client. Walk on the weakest side and encourage the client to use his or her strong arm to hold handrail, if available.		

16. Walk in the same pattern as the client (both step with left feet at the same time). Help the client to step forward with strong foot first.		
17. Walk the client the distance instructed by supervisor.		
18. Return the client to bed/chair.		
19. Remove gait belt.		
20. Make sure client is comfortable.		
21. Place call signal within reach.		
22. Wash your hands.		
23. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "AMBULATE CLIENT WITH A GAIT BELT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 3: Ambulation

Skill Sheet

AMBULATE CLIENT USING A WALKER

Student Name ______________________________ Date ________________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Gait belt
3. Walker appropriate for client
4. Wheelchair or armchair

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet the client.		
3. Identify self.		
4. Explain what you are going to do.		
5. Make sure client has on appropriate attire for ambulation.		
6. Lower bed to lowest level.		
7. Assist the client to sit on the edge of bed.		
8. Pause and allow the client to sit a few moments to regain balance.		
9. Help the client put on nonskid shoes and socks.		
10. Apply a gait belt.		
11. Stand in position of good body mechanics.		
12. Assist the client to a standing position.		
13. Instruct the client to position body within the frame of the walker.		
14. Instruct the client to move the walker forward by lifting it up.		
15. Instruct the client to take a step forward with the weak leg while supporting self with walker and stronger leg.		
16. Instruct the client to move strong leg forward.		
17. Walk the client the distance instructed by supervisor.		

18. Return the client to bed/chair. To ambulate backward, the client steps backward with his or her strong foot, takes a step back with the weak foot, then moves the walker back. Have the client feel with his or her hand for the chair arm or the mattress.		
19. Remove gait belt.		
20. Make sure client is comfortable.		
21. Place call signal within reach.		
22. Wash your hands.		
23. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "AMBULATE CLIENT USING A WALKER" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 3: Ambulation

Skill Sheet

AMBULATE CLIENT USING A CANE

Student Name ________________________________ Date ________________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Gait belt
3. Cane appropriate for client
4. Wheelchair or armchair

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet the client.		
3. Identify self.		
4. Explain what you are going to do.		
5. Make sure client has on appropriate attire for ambulation.		
6. Lower bed to lowest level.		
7. Assist the client to sit on edge of bed.		
8. Pause and allow the client to sit a few moments to regain balance.		
9. Help the client put on nonskid shoes and socks.		
10. Apply a gait belt.		
11. Stand in position of good body mechanics.		
12. Assist the client to a standing position.		
13. Instruct the client to take short steps and keep head up and eyes looking forward.		
14. Instruct the client to move cane forward and a little out to the side of the strong leg.		
15. Instruct the client to move weak extremity forward to line up evenly with the tip of cane just after cane is placed.		
16. Instruct the client to put weight on cane and his or her weak foot while swinging the strong foot forward, taking a step.		

17. Walk in the same pattern as the client (both step with the left foot at the same time).		
18. Walk the client the distance instructed by supervisor.		
19. Return the client to bed/chair.		
20. Remove gait belt.		
21. Make sure client is comfortable.		
22. Place call signal within reach.		
23. Wash your hands.		
24. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "AMBULATE CLIENT USING A CANE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 3: Ambulation

Skill Sheet

AMBULATE CLIENT WITH THREE-POINT, NONWEIGHTBEARING GAIT USING CRUTCHES AND CONTACT ASSISTANCE

Student Name ________________________________ Date ______________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Gait belt
3. Crutches appropriate for client
4. Wheelchair or armchair

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Identify and greet client.		
3. Identify self.		
4. Explain what you are going to do.		
5. Make sure client has on appropriate attire for ambulation.		
6. Lower bed to lowest level.		
7. Assist the client to sit on edge of bed.		
8. Pause and allow the client to sit a few moments to regain balance.		
9. Help the client put on nonskid shoes and socks as appropriate.		
10. Apply gait belt.		
11. Stand on the side of the client's affected leg. Position crutches to front and side of bed on affected side, and have client hold crutches at handholds. NOTE: Use good body mechanics throughout procedure.		
12. Ask client if he or she is ready to stand up; grasp gait belt in back with one hand, and place opposite hand lightly at client's shoulder.		
13. Ask client to stand up without putting weight on affected foot. Give client a moment to regain balance.		
14. Observe as client uses free hand to grasp the hand hold of a crutch and place it under arm on unaffected side.		
15. Observe as client rotates other crutch around and under arm on affected side.		

16. Allow client time to adjust clothing and crutches for comfort and to be sure crutches are securely under arms.		
17. Ask client if he or she is ready to ambulate. Have client hold affected leg off floor and move crutches forward, steadying at gait belt and shoulder if necessary.		
18. Remain in contact with the client as he or she presses down with hands and swings unaffected foot forward, keeping affected foot off floor.		
19. Continue ambulating to the specified distance.		
20. Return client to chair, allowing client to back up to the chair until the back of the unaffected leg touches it.		
21. Remain in contact while client takes crutch out from under arm on affected side and holds it by the handpiece.		
22. Observe as client takes crutch out from under unaffected side and moves it to the hand on the affected side so that the two crutches are lined up.		
23. Observe and assist as necessary as client reaches back to grasp arm of chair on unaffected side and sits down.		
24. Move crutches out of the way.		
25. Remove gait belt.		
26. Make sure client is comfortable.		
27. Place call signal within reach.		
28. Wash hands.		
29. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "AMBULATE CLIENT WITH THREE-POINT, NONWEIGHTBEARING GAIT USING CRUTCHES AND CONTACT ASSISTANCE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 4: Range of Motion Exercises

Skill Sheet

PERFORM RANGE OF MOTION EXERCISES

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bed with side rails if appropriate
2. Pillow

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet the client.		
3. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy. The client should wear adequate clothing.		
6. Raise bed to a comfortable working height.		
7. Assist the client into supine position.		
8. Neck a. Flexion/Extension (1) Support head with hands and bend head forward, trying to touch the chest with the chin.		
(2) Bring head back to pillow.		
b. Right and left rotation - turn head from side to side.		
9. Shoulders a. Flexion/Extension (1) Support the arm at the wrist and elbow and lift the arm toward the ceiling. Continue lifting the arm over the client's head until you feel resistance.		
(2) Slowly lower the arm to the client's side.		
b. Abduction/Adduction (1) Support the arm at the elbow and shoulder and move the arm out to the side, continue moving toward the client's head.		

(2) Slowly move the arm back toward the center of body.		
c. Lateral/Medial Rotation (1) Move the arm away from the body to shoulder level.		
(2) Bend the elbow at a 90° angle. Rotate the hand forward to touch the bed and then backward to touch the bed.		
10. Elbows a. Flexion/Extension (1) Bend the arm at the elbow and touch the shoulder, then straighten the arm.		
(2) Bend the arm at the elbow and touch the chin, then straighten the arm.		
b. Supination/Pronation (1) Hold the client's hand in a handshake position; support the arm at the elbow joint with the elbow slightly bent.		
(2) Turn palm of the hand up then downward.		
11. Wrists a. Flexion/Extension/Hyperextension - support arm and hand; bend the wrist forward, straighten it, and then bend it backward.		
b. Abduction/Adduction - move the hand from side to side at the wrist.		
12. Fingers a. Flexion/Extension - support the hand at the wrist; make sure that the thumb is on top of the fingers. Instruct the client to make a clenched fist and then relax it.		
b. Abduction/Adduction - move each finger away from the nearest finger and then return it.		
c. Thumb Opposition - bend the little finger toward inner hand and stretch the thumb toward the little finger and move it to the base of the little finger and back.		
d. Thumb Rotation - move the thumb in a circle one direction and then the other direction.		
13. Hips and Knees a. Flexion/Extension (1) Support the leg at the knee and ankle joints, keep the knee straight; raise and lower the leg.		
(2) Bend the knee and move toward the chest, slowly straighten the knee.		

b. Abduction/Adduction (1) Move the leg straight out to the side of the body until you feel resistance.		
(2) Slowly move the leg back toward the center of the body.		
c. Lateral/Medial Rotation - support the knee and ankle joints; roll the leg in toward the opposite leg and then outward.		
14. Ankles and Feet a. Inversion/Eversion - support the foot at the ankle joint and turn the sole of the foot toward the opposite foot and then away from the opposite foot.		
b. Dorsiflexion/Plantarflexion - bend the foot up toward the knee, then down toward the floor.		
15. Toes a. Flexion/Extension - bend and then straighten the toes.		
b. Abduction/Adduction - move each toe toward the next toe and then away from the next toe.		
16. Lower bed to lowest position.		
17. Raise side rails if ordered.		
18. Make the client comfortable.		
19. Place call signal within reach.		
20. Wash your hands.		
21. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "PERFORM RANGE OF MOTION EXERCISES" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Written Unit Evaluation

Student Name ______________________________ Date ______________

Circle the letter that corresponds to the best answer.

1. What is the preferred position for meals for a client who does NOT go to the dining room?

    a. Supine in bed
    b. In a chair, using an overbed table
    c. With the head of the bed elevated to its highest position
    d. On the side of the bed

2. What should be done with trays when the client is NOT ready to eat when the tray is delivered?

    a. Send the tray back to the dietary department until the client is read to eat
    b. Take the tray to the client and leave it until it can be eaten
    c. Place the tray back on the serving cart or keep it warm some way
    d. Dispose of the tray and reorder the food when the client is ready to eat

3. What is dysphagia?

    a. Indigestion
    b. Paralysis of one side of the mouth
    c. Alternate method of nutrition
    d. Difficulty swallowing

4. To assist the client who is blind to eat independently, which action is most appropriate?

    a. Give the client a spoon with which to eat
    b. Thicken the liquids so the client is less likely to choke
    c. Place the food items in the same place on the tray at each meal
    d. Remove liquids from the tray to prevent spills

5. What should be considered when preparing meals in a client's home?

    a. Discuss and prepare a shopping list with the client
    b. Contact an outside source for food, i.e. Meals on Wheels
    c. Prepare meals as instructed by the client's family members
    d. Purchase only foods that the the nurse assistant can prepare

6. For clients allowed ice, fill pitchers:

    a. 1/4 full of ice.
    b. 1/3 full of ice.
    c. 2/3 full of ice.
    d. 3/4 full of ice.

7. What is the most common type of scale used in health care facilities?

   a. Bathroom
   b. Upright
   c. Chair
   d. Digital

8. The large weight indicator on a balance scale or upright scale is marked in increments of:

   a. One pound.
   b. Ten pounds.
   c. Fifty pounds.
   d. One hundred pounds.

9. When measuring height of a client in bed, the client should be in which position?

   a. Supine
   b. Transverse
   c. Fowler's
   d. Prone

10. If a client's height is 66 inches, what is the height recorded in feet and inches?

    a. 4 feet, 10 inches
    b. 5 feet, 2 inches
    c. 5 feet, 4 inches
    d. 5 feet, 6 inches

11. If the client is incontinent, how is output recorded?

    a. The incontinent brief is weighed.
    b. The total output of fluids is estimated.
    c. The output cannot be recorded.
    d. The number of times the client voids is recorded.

12. When giving frequent fluids, the nurse assistant will be most successful with which of these strategies?

    a. Offer large amounts of fluids with meals.
    b. Give the client water only.
    c. Give small amounts of a variety of fluids frequently.
    d. Discourage the client from eating a large meal.

13. What is a consideration in preparing a client for a meal?

    a. The client's hands should be washed after he or she is taken to the dining room.
    b. The client's glasses and/or hearing aid(s) should be removed.
    c. The client's dentures should be removed and placed in a cup to soak.
    d. The client should be offered a bedpan or urinal or assisted to the bathroom.

14. The taste of food is enhanced by what types of increased sensory input?

    a. The sound of pleasant conversation or music
    b. The window shades are adjusted to decrease sunlight
    c. Fresh flowers are removed to prevent allergic reactions
    d. Increasing the volume of a television or radio over lunchroom noise

15. The client can be left alone to eat as soon as:

    a. The food tray is placed on the client's table.
    b. The room has been sprayed with deodorizer to remove smells.
    c. The nurse assistant determines that they can manage on their own.
    d. The serving cart has been moved to prevent contamination of other clients' meals.

16. When feeding a client, food should be served:

    a. Solids first, then fluids.
    b. Crisp foods first, then smooth ones.
    c. In the order of the client's preference.
    d. Alternating fluids and solids as the physician prescribes.

17. The spoon or fork should be filled to what level when offering a bite to a client?

    a. Completely full when the client is very hungry.
    b. Half full to prevent spilling and ease for the client to manage.
    c. One quarter full when the food has extremely hot spices added.
    d. One quarter full when the patient is fatigued, but needs to finish.

18. When a client has a paralyzed side, the nurse assistant should place the food in:

    a. The side of his or her mouth that is paralyzed.
    b. The side of his or her mouth that is not paralyzed.
    c. The back of his or her mouth for ease in swallowing.
    d. The middle of his or her mouth to aide in muscle therapy.

19. The bag for a nasogastric feeding should be kept:

    a. Above the level of the stomach.
    b. Below the level of the stomach.
    c. Even with the level of the stomach.
    d. As close to the stomach as possible.

20. The client should be weighed at the same time every day for what reason?

    a. For convenience to the client
    b. To meet state requirements
    c. For accuracy in weighing
    d. To maintain safety

21. Clients in long-term care are routinely weighed:

    a. Every day.
    b. Every other day.
    c. At least once a week.
    d. At least once a month.

22. Which of the following is measured as fluid output in clients?

    a. Diaphoresis (profuse sweating)
    b. Urine, emesis and diarrhea
    c. Drainage from a wound
    d. All of the above

23. Output from a catheter should be measured:

    a. Only once a day.
    b. Using a graduate for accuracy.
    c. Using the scale on the side of the bag.
    d. Only when the physician orders a measurement.

24. If a client weighs 65 kilograms, what is their equivalent weight in pounds?

    a. 136
    b. 140
    c. 143
    d. 157

Match the words in Column A with the correct definition or description from Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

COLUMN A

______ 25. Intravenous infusion

______ 26. Hyperalimentation

______ 27. Central line

______ 28. NG tube

______ 29. G tube

______ 30. Edema

______ 31. Dehydration

______ 32. Frequent fluids

______ 33. Restricted fluids

______ 34. After-meal care

COLUMN B

a. Highly concentrated solution of nutrients

b. Encouraging more than the usual intake of fluids

c. Wash the client's hands and face

d. Storage of fluid in tissues

e. Fluid given directly into a vein through a needle

f. Fluid eliminated from the body

g. Intravenous line inserted into a large vein

h. Tube surgically inserted directly into the stomach

i. Condition that results when intake is less than output

j. Fluid balance

k. Tube inserted through the nose to the stomach

l. Limiting the amount of fluids ingested

m. Liquids which are recorded as intake

n. Elevate bed as high as client can tolerate

Lesson 1: Preparing the Client for Meals: Serving, Feeding and Monitoring

Skill Sheet

FEED A HELPLESS CLIENT

Student Name ________________________________ Date ________________

EQUIPMENT:

1. Food tray
2. Napkins or towel
3. Overbed table or other table to set food tray on
4. Chair

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Provide before-meal care: offer the client a bedpan or urinal; wash the client's hands and face; position the client in a sitting position.		
3. Wash your hands.		
4. Check the food tray before serving to make sure it is the correct one.		
5. Place the food tray in front of the client on an overbed table.		
6. Explain that you will help the client eat.		
7. Spread the napkin or towel to protect clothes and linen.		
8. Sit down in a chair facing the client.		
9. Prepare the food: cut up meat, butter bread, pour tea or coffee, etc.		
10. Season the food as the client wishes within his or her dietary guidelines.		
11. Ask the client in what order he or she wants the food served; name each mouthful of food as you offer it.		
12. Let the client do as much as possible.		
13. Use straws or a double-handled cup for liquids.		
14. Warn the client when serving something hot.		
15. Use a spoon to give small bites and feed the client slowly, allowing time for chewing, swallowing, and breathing.		

16. Alternate liquids and solids.		
17. Wipe the client's mouth as needed.		
18. Take the tray away as soon as the client is finished.		
19. Note the foods and amounts eaten.		
20. Provide after-meal care: wash the client's hands and face; remove napkin; make the client comfortable; place the call device within reach.		
21. Wash your hands.		
22. Record pertinent observations and report anything unusual to supervisor.		

The student has satisfactorily completed the procedure "FEED A HELPLESS CLIENT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 2: Intake and Output

Skill Sheet

DISTRIBUTE DRINKING WATER

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Pitchers
2. Glasses
3. Trays
4. Cart
5. Water
6. Ice
7. Ice tongs or large spoon

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Check with the charge nurse to identify which clients are not allowed water.		
3. Check the care plan to identify the clients who do not want or are not allowed ice.		
4. Collect pitchers, glasses, and trays from the bedside of clients and place them on a cart or tray.		
5. Take the cart or tray of equipment to the dietary department or clean utility room.		
6. Obtain clean pitchers and glasses.		
7. For clients allowed ice, fill pitchers 1/3 full of ice; use ice tongs or a large spoon to handle ice.		
8. Add water to fill pitchers.		
9. Return pitchers promptly to clients' bedside tables.		

The student has satisfactorily completed the procedure "DISTRIBUTE DRINKING WATER" according to the steps outlined.

______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion) Date

Lesson 2: Intake and Output

Skill Sheet

MEASURE FLUID INTAKE

Student Name ______________________________ Date ______________

EQUIPMENT:

1. I&O form
2. Pencil

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Obtain a list of the most commonly used fluid containers in the facility or home.		
2. Wash hands.		
3. Identify self.		
4. Identify client.		
5. Explain to the client how he or she can assist by writing down the amount and kind of fluids taken (if the client is able to do so).		
6. Have a form for recording intake and output available.		
7. Measure and record all fluids consumed by the client during the shift. a. Record intake after each meal before the tray is removed.		
b. Record other intake as it is consumed.		
8. Wash hands.		

The student has satisfactorily completed the procedure "MEASURE FLUID INTAKE" according to the steps outlined.

______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion) Date

Lesson 2: Intake and Output

Skill Sheet

MEASURE FLUID OUTPUT

Student Name ________________________________ Date ______________

EQUIPMENT:

1. Gloves
2. Measuring container
3. I&O form
4. Pencil

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Identify the client.		
2. Identify self.		
3. Explain how the client can assist by capturing all output in a bedpan or other measuring container.		
4. Have a form available for recording output.		
5. Wash hands.		
6. Put on gloves.		
7. Using a measuring container, measure each void, liquid stool, emesis, or other liquid output.		
8. Discard output in toilet.		
9. Rinse the measuring container.		
10. Dispose of the gloves.		
11. Wash hands.		
12. Record output on form.		

The student has satisfactorily completed the procedure "MEASURE FLUID OUTPUT" according to the steps outlined.

______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion) Date

Lesson 3: Weight and Height

Skill Sheet

MEASURE WEIGHT AND HEIGHT ON AN UPRIGHT SCALE

Student Name ________________________________ Date ________________

EQUIPMENT:

1. Upright scale
2. Paper towel
3. Paper
4. Pencil

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Assemble the necessary equipment.		
3. Identify and greet the client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Place a paper towel on the scale platform.		
8. Raise the measuring rod.		
9. Ask the client to remove his or her robe and slippers; provide assistance if necessary.		
10. Assist the client to stand on the scale platform; have the client stand with his or her arms to sides.		
11. Read the weight. NOTE: If using a balance scale, move the weight until the pointer swings evenly between the top and bottom of the metal square.		
12. Record the weight.		
13. Instruct the client to stand erect with his or her back to the measuring rod.		
14. Lower the measuring rod until it rests on the client's head.		
15. Read and record the height.		

16. Raise measuring rod.		
17. Assist the client off the platform.		
18. Assist the client in putting on his or her robe and slippers.		
19. Assist the client to his or her bed or chair.		
20. Discard the paper towel.		
21. Remove, clean, and store equipment.		
22. Wash hands.		
23. Make the client comfortable; place the call device within reach.		
24. Report unusual occurrences to the supervisor.		

The student has satisfactorily completed the procedure "MEASURE WEIGHT AND HEIGHT ON AN UPRIGHT SCALE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 3: Weight and Height

Skill Sheet

MEASURE WEIGHT AND LENGTH OF AN INFANT

Student Name ________________________ Date ____________

EQUIPMENT:

1. Infant scale
2. Tape measure, if not on scale
3. Tissue paper
4. Pencil
5. Paper

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Assemble equipment.		
3. Prepare scale: balance at zero, cover with tissue paper.		
4. Identify infant.		
5. Provide privacy.		
6. Pick up infant correctly.		
7. Remove infant's clothing and diaper.		
8. Place infant on scale. CAUTION: Keep one hand by infant at all times.		
9. Move weight until pointer swings evenly.		
10. Read scale.		
11. Record weight.		
12. If length measuring device is on scale, position infant supine with head touching metal plate. Otherwise place infant on flat surface.		
13. Measure length. a. If measuring device is on scale, hold one hand on infant's trunk and use the other hand to straighten the legs.		

b. If using a tape measure, place tape measure with zero mark at infant's head. Place other end of tape by infant's heel. Hold one hand on infant's trunk and use the other hand to straighten the legs.		
14. Read measuring device at heel.		
15. Record length.		
16. Dress infant.		
17. Return infant to crib or parent.		
18. Clean, move, and store equipment.		
19. Wash hands.		
20. Report unusual occurances to supervisor.		

The student has satisfactorily completed the procedure "MEASURE WEIGHT AND LENGTH OF AN INFANT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Written Unit Evaluation

Student Name ______________________________ Date ______________

Circle the letter that corresponds to the best answer.

1. Elderly clients may experience confusion on admission because:

    a. They are expected to be more independent.
    b. They are in unfamiliar surroundings.
    c. They must make decisions.
    d. Their families are with them.

2. Which of the following activities is the nurse assistant responsible for when a client is admitted?

    a. Performing a baseline assessment on the client
    b. Determining whether specimens need to be collected
    c. Answering questions about the client's medical condition
    d. Taking the client's vital signs and measuring height and weight.

3. Which of the following activities is the nurse assistant responsible for when a client is transferred?

    a. Deciding when a client needs to be transferred from one unit to another
    b. Unpacking a client's belongings after he or she is moved to a new unit
    c. Giving medical information about a client to the staff on a new unit
    d. Introducing a client to the staff members on a new unit

4. Which of the following activities is the nurse assistant responsible for when a client is discharged?

    a. Assisting the client in gathering all personal belongings
    b. Answering questions about the client's medical condition
    c. Giving discharge instructions to the charge nurse
    d. Transporting the client to the new facility

5. What should the nurse assistant expect for normal urine output over a 24-hour period?

    a. 200 to 300 cc's
    b. 500 to 1,000 cc's
    c. 1, 000 to 1,500 cc's
    d. 1, 500 to 2,000 cc's

6. When encouraging fluids for a client, what can be done to prevent the client from having to get up to void during the night?

   a. Restrict intake to 2,000 cc's of fluid per 24-hour period.
   b. Give fluids between 7:00 a.m. and 7:00 p.m.
   c. Make sure the client is getting enough salt.
   d. Restrict fluids after 10:00 p.m.

7. Which of the following is a general consideration in giving a bedpan or urinal?

   a. Disinfect the urinal each time it is used.
   b. The urinal may be emptied into the sink if necessary.
   c. The bedpan may be placed on the floor if the client must be repositioned.
   d. Sprinkle powder on the bedpan's rim to reduce friction on the client's skin.

8. When assisting a client with a bedpan, what is an important consideration?

   a. Assist the client onto the bedpan by lifting at the knees.
   b. Do not leave the client on the bedpan for more than ten minutes.
   c. Place the client in an upright position before positioning the bedpan.
   d. Use both hands to roll the client off the bedpan if he or she is unable to assist.

9. If a client is to be catheterized once to drain his or her bladder and the catheter will not remain in the bladder, which type of catheter will most likely be used?

   a. Foley catheter
   b. Texas catheter
   c. French catheter
   d. Indwelling catheter

10. Urine will drain more freely if the tubing is:

    a. Coiled on the bed.
    b. Laid on the floor by the bed.
    c. Hung above the level of the bladder.
    d. Hung below the level of the drainage bag.

11. What should the nurse assistant do before beginning bladder training with a client?

    a. Obtain a bedside commode.
    b. Observe the client's voiding intervals.
    c. Determine what type of incontinence the client has.
    d. Keep the patient hydrated and the urine diluted with extra fluids.

12. When a client requires incontinent briefs, the nurse assistant should:

    a. Change them only when giving baths.
    b. Use them as a substitute for toileting a client.
    c. Refer to them as diapers so the client understands.
    d. Check them frequently and change them as needed.

13. If bleeding occurs high in the gastrointestinal tract, the client's stool will be:

    a. Very dark, almost black, and slightly sticky
    b. Bright red and liquid in consistency
    c. Green-tinged or yellow
    d. Light brown

14. How does adding fiber to the client's diet maintain normal bowel elimination?

    a. It is hard to digest, stimulating the bowel to move.
    b. It is irritating to the bowel, causing the bowel to contract.
    c. It loosens the sphincters, making it easier to pass the stool.
    d. It makes the stool softer, allowing it to move through the bowel easier.

15. What should a nurse assistant use if he or she is told to administer a saline enema?

    a. A commercially prepared solution ready to administer
    b. A solution of tap water and liquid detergent
    c. A solution of tap water and salt
    d. An enema of plain tap water

16. Which is the preferred position for the client for administration of an enema?

    a. Left lateral or Sims'
    b. Transverse
    c. Fowler's
    d. Supine

17. When administering an enema:

    a. Force the tubing in if any resistance is encountered.
    b. Hold the bag so that it is two feet above the client's anus.
    c. Ask the client to take shallow breaths during the procedure.
    d. Ask the client to take a deep breath while the tube is inserted.

18. What is a bowel training program designed to do?

    a. To promote bowel incontinence
    b. To encourage the use of digital stimulation
    c. To establish a regular schedule of elimination
    d. To decrease the time between bowel elimination

19. Which of the following is a general principle of ostomy care?

    a. Keep the skin around the stoma wet.
    b. Observe the stoma weekly for abnormalities.
    c. Empty the collection bag at routine intervals.
    d. Allow collection bag to fill completely before emptying.

20. When changing a disposable ostomy bag, the nurse assistant should:

    a. Place the bag in a bedpan.
    b. Place the bag in a plastic waste bag.
    c. Clean out the bag with soap and water.
    d. Dispose of wiping tissue in the ostomy bag.

Match the conditions in Column A with the correct descriptions in Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

COLUMN A

____21. Stress incontinence

____22. Urge incontinence

____23. Neurogenic incontinence

____24. Functional incontinence

____25. Cystitis

____26. Hematuria

____27. Nephritis

____28. Renal calculi

____29. Urinary retention

COLUMN B

a. Inability to control urine passage when pressure is placed on the bladder

b. High frequency sound waves used to break or dislodge kidney stones

c. Inability to empty the bladder

d. Infection of the bladder

e. Occurs when a catheter is removed

f. Inability to control the passage of urine

g Disease condition that creates strong urges or bladder contractions

h. Kidney stones

i. Blood in the urine

j. Pattern of voiding

k When injury or disease interupts the pathways of sensation to the bladder

l. Inability to retain urine long enough to get to the bathroom

m. Inflammation of the kidney

Match the conditions in Column A with the correct descriptions in Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

COLUMN A

____30. Peristalsis

____31. Defecation

____32. Constipation

____33. Impaction

____34. Distended

____35. Diarrhea

____36. Hemorrhoids

____37. Laxative

____38. Enema

____39. Digital stimulation

COLUMN B

a. Varicose veins in the rectum

b. Massage of the internal anal canal

c. Passage of unusually dry, hard stool

d. Wave of contractions within the bowel

e. Infusion of fluid into the rectum

f. Passage of liquid stool

g. Substance eliminated from the bowel

h. Hard mass of stool that cannot be passed normally

i. Medication to promote peristalsis

j. Elimination of stool

k. Blockage of the bowel

l. Rounded, full abdomen

Match the conditions in Column A with the correct descriptions in Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

COLUMN A

____40. Ostomy

____41. Stoma

____42. Colostomy

____43. Ileostomy

____44. Ureterostomy

____45. Ileal conduit

COLUMN B

a. Introducing fluid into a stoma

b. Opening on the abdomen for the ureter

c. Opening made on the outside of the body

d. Opening into the ileum

e. Maintaining the new opening

f. Surgically made opening through the abdomen wall into an organ

g. Section of bowel used to make a pouch

h. Collection bag

i. Opening into the colon

Circle the letter that corresponds to the best answer.

46. What is the purpose of collecting specimens of body products?

a. To help the body get rid of waste products
b. To identify the by-products of the body's processes
c. To free the body from harmful substances and microorganisms
d. To assist in diagnosing illness and evaluating the effectiness of treatment

47. What should be done with an unlabeled specimen?

a. It should be sent to the lab.
b. It should be thrown away to avoid mistakes.
c. It should be kept until someone can identify it.
d. It should be kept until the nurse assistant can check the charts to see which client has had a specimen taken.

48. When collecting a clean catch urine specimen:

a. Be sure to remove your gloves when catching the urine stream.
b. Be sure to pull the labia back on an uncircumcised male.
c. Be sure that the container does not touch the client.
d. Be sure to touch the inside of the container lid.

49. When collecting a 24-hour urine specimen, discard:

a. The urine voided at the beginning of the collection period.
b. The urine voided at the end of the collection period.
c. The urine voided halfway through the period.
d. All of the urine.

50. When collecting a sterile specimen from a closed urinary drainage system:

a. Never clamp the drainage tubing.
b. Always clean the speci-port with water.
c. Never leave a client without unclamping the tubing.
d. Always drain the urine from the tubing directly into the container.

51. The nurse assistant should collect__________________ of feces from different areas of a client's stool.

a. 1-2 teaspoons
b. 1-2 tablespoons
c. 2-3 tablespoons
d. 3-4 tablespoons

52. When is usually the best time to collect a sputum specimen?

    a. Early in the morning
    b. Early afternoon
    c. Late afternoon
    d. At bedtime

53. After heat or cold has been applied, how soon should the nurse assistant go back to check it for the first time?

    a. 5 minutes
    b. 15 minutes
    c. 30 minutes
    d. 1 hour

54. The purpose of a heat application is to:

    a. Dilate blood vessels and increase blood flow.
    b. Dilate blood vessels and decrease blood flow.
    c. Constrict blood vessels and increase blood flow.
    d. Constrict blood vessels and decrease blood flow.

55. The most effective way heat can be applied to the entire body is by:

    a. Giving a sitz bath to a client.
    b. Applying compresses to a client's body.
    c. Placing a client in a tub of warm water.
    d. Connecting a client to an aquathermia pad.

56. Which of these observations of a client would indicate a complication of a heat application?

    a. Cyanotic, mottled skin
    b. Red, blistered skin
    c. White, scaly skin
    d. Pale, moist skin

57. Who determines the temperature of the water used in applying warm, moist compresses?

    a. The client
    b. The nurse assistant
    c. The supervisor
    d. The physician

58. After a heat application, a warm water bottle should be:

    a. Left to air dry at room temperature.
    b. Dried inside and stored deflated in a cool place.
    c. Dried inside and outside and stored inflated in a cool place.
    d. Dried outside and stored inflated at regular room temperature.

59. What is the purpose of applying cold to the entire body?

    a. To reduce oxygen and nutrients supplied to the body
    b. To keep the body from producing waste
    c. To reduce a high body temperature
    d. To cause the blood vessels to dilate

60. Which of the following are all moist, cold types of applications?

    a. Compresses, packs and soaks
    b. Tub baths, ice caps and ice collars
    c. Compresses, water bottles and tub soaks
    d. Ice caps, water bottles and commercially prepared chemical packs

61. Which of these observations of a client would indicate a complication of a cold application?

    a. Pale, moist skin
    b. Red, blistered skin
    c. Cyanotic, scaly skin
    d. Cyanotic, blistered skin

62. When preparing an ice bag for a cold application, it should be filled:

    a. ½ to 2/3 full.
    b. 2/3 to 3/4 full.
    c. 3/4 to almost full.
    d. As full as possible.

63. What is meant by clean technique when applying dressings?

    a. The wound is cleaned thoroughly.
    b. The wound is cleaned with antibacterial soap and ointment is applied.
    c. The dressing is kept as free as possible from contamination by bacteria.
    d. The dressing has medication on it to prevent contamination of the wound.

64. When removing an old dressing, the nurse assistant should:

    a. Observe and record the amount and color of drainage on it.
    b. Let it dry out completely before disposing of it.
    c. Place it in a paper or plastic sack.
    d. Send it to the lab for analysis.

65. What is the cause of a pressure ulcer?

    a. Lack of personal hygiene
    b. Shearing of the top layers of skin
    c. Failure to use clean technique in treating wounds
    d. Lack of blood flow to the skin and the tissues underneath

66. Pressure ulcers usually develop:

    a. Where skin wrinkles.
    b. Where muscles attach to bones.
    c. Where there are thin layers of skin over muscles.
    d. Where bones come close to the surface of the body.

67. Stage III of a pressure ulcer is defined by:

    a. Bluish, mottled skin.
    b. An open sore with all layers of skin involved.
    c. Red and tender skin that is slightly warm to touch.
    d. Distruction of tissue extending to muscle and/or bone.

68. Which of the following are NOT prone to pressure ulcers?

    a. Paralyzed clients who have sensory deficits
    b. Young and well-nourished clients
    c. Thin and malnourished clients
    d. Obese and incontinent clients

69. The nurse assistant can help prevent pressure ulcers by:

    a. Tightening bed linens.
    b. Placing pillows under client's knees.
    c. Turning clients infrequently so they have less stress.
    d. Maintaining constant air pressure in specially made mattresses.

70. What is an advance directive?

    a. Directions whether a client is to be buried or cremated
    b. Directions about the care the family expects a client to receive
    c. Directions from a client about which measures to prolong life should be performed
    d. Directions as to what procedures are to be used on a client's body after he or she dies

71. Which of the following is a sign of approaching death?

    a. Rigor mortis
    b. Fast, weak, irregular pulse
    c. Permanently dilated pupils
    d. Flushed skin on the feet and legs

72. What should be done during postmortem care to prevent discoloration of the face?

a. Elevate the head slightly.
b. Protect the face from light.
c. Keep the client in a supine position.
d. Remove secretions and close the eyes.

Match the conditions in Column A with the correct descriptions in Column B. Place the letter of your choice on the line to the left of the question number. The choices from Column B may be used once or not at all.

COLUMN A

____73. Urinalysis

____74. Wound

____75. Incision

____76. Sutures

____77. Excoriation

____78. Lesion

____79. Pustule

____80. Vesicle

____81. Necrotic

____82. Rigor mortis

COLUMN B

a. Raised area filled with clear tissue fluid

b. Solid waste product of the digestive system

c. Rigidity of the body occuring 4 to 8 hours after death

d. A special type of thread used to sew surgical wounds together

e. Lesion filled with pus

f. End stage of life

g. Accidental or deliberate injury to skin

h. A series of tests determining the composition of urine

j. Caused by scratching

k. Dead tissue

l. Measures to prolong life

m. Surgical wound made by a deliberate cut

n. Change in skin due to disease or allergic condition

Lesson 2: Urinary Elimination

Skill Sheet

ASSIST CLIENT WITH URINAL

Student Name ________________________________ Date ____________

EQUIPMENT:

1. Urinal and cover
2. Washcloth
3. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Put on gloves.		
3. Assemble necessary equipment.		
4. Identify and greet client.		
5. Identify self.		
6. Explain what you are going to do.		
7. Provide privacy.		
8. Turn back top bedding, except top sheet (to provide privacy).		
9. Adjust client's clothing to expose perineal area.		
10. Place client's penis in urinal and lay urinal between his legs.		
11. Make sure urinal is placed at an angle to keep urine from spilling out; flat edge should be lying on bed.		
12. Remove and appropriately dispose of gloves.		
13. Wash hands.		
14. Place call device within reach and leave room.		
15. Return to room promptly when client calls.		
16. Wash hands.		
17. Put on gloves.		
18. Remove and cover urinal. Take it to bathroom.		

19. Measure urine if client is on intake and output and empty urine into toilet.		
20. Clean equipment.		
21. Remove and appropriately dispose of gloves.		
22. Wash hands.		
23. Store equipment.		
24. Give client clean, wet washcloth to wash hands.		
25. Place soiled washcloth in appropriate container.		
26. Wash hands.		
27. Make client comfortable.		
28. Place call device within reach, if appropriate.		
29. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "ASSIST CLIENT WITH URINAL" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 2: Urinary Elimination

Skill Sheet

ASSIST CLIENT WITH BEDPAN

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Bedpan and cover
2. Toilet tissue
3. Small pillow or rolled towel
4. Basin with warm water
5. Soap
6. Washcloths, towel
7. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Put on gloves.		
3. Assemble necessary equipment.		
4. Identify and greet client.		
5. Identify self.		
6. Explain what you are going to do.		
7. Provide privacy.		
8. Place client in supine position or as close to supine position as possible.		
9. Turn back top bedding, except top sheet (to provide privacy).		
10. If client is able to assist a. Have client flex knees and lift buttocks off mattress. Assist by slipping hand under lower part of back. Adjust client's clothing to expose perineal area.		
b. With other hand, slip bedpan under client's hips and adjust it appropriately.		
If client is unable to assist a. Turn client on side, facing away from you.		
b. Expose client's buttocks and position bedpan firmly against buttocks.		

c. Place small pillow or rolled towel at top of bedpan at small of client's back.		
b. Turn client toward you and onto bedpan.		
11. Raise head of bed (if allowed) and side rails for client's comfort and safety.		
12. Place toilet tissue and call device within reach.		
13. Remove and appropriately dispose of gloves.		
14. Wash hands and leave room.		
15. Return to room promptly when client calls, or check after five minutes. NOTE: DO NOT leave client on bedpan for more than ten minutes; doing so may lead to extreme discomfort and result in skin breakdown.		
16. Wash hands.		
17. Put on gloves.		
18. Lower head of bed and side rail next to you.		
19. If client is able to assist - Place one hand under small of client's back and assist client in raising hips. Hold bedpan with other hand.		
If client is unable to assist - Hold bedpan with one hand to prevent contents of bedpan from spilling, and roll client off bedpan with other hand.		
20. Remove bedpan and cover it.		
21. Wipe, wash and dry perineal area from front to back.		
22. Take bedpan to bathroom; measure urine if client is on intake and output, and empty into toilet.		
23. Clean equipment.		
24. Remove and appropriately dispose of gloves.		
25. Wash hands.		
26. Store equipment.		
27. Give client clean, wet washcloth to wash hands.		
28. Place soiled washcloth in appropriate container.		
29. Wash hands.		
30. Make client comfortable.		
31. Place call device within reach, if appropriate.		

32. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "ASSIST CLIENT WITH BEDPAN" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 2: Urinary Elimination

Skill Sheet

CHANGE A DRAINAGE BAG

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Drainage bag and cap
2. Alcohol swabs
3. Sterile gauze
4. Alcohol packet
5. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Put on gloves.		
3. Assemble necessary equipment.		
4. Identify and greet client.		
5. Identify self.		
6. Explain what you are going to do.		
7. Provide privacy.		
8. If applying reusable leg bag, swab end to be connected to catheter tubing with alcohol and place on sterile gauze in alcohol packet. Do not allow it to touch anything else.		
9. Crimp catheter tubing with fingers or clamp so urine does not flow.		
10. Disconnect catheter tubing from drainage bag. If drainage bag is to be reused, apply cap over end of tubing.		
11. Connect bag to catheter.		
12. Unclamp catheter tubing.		
13. Check to see that urine is flowing; it may take a few minutes.		
14. If placing leg bag or applying new tape, allow enough slack so that bag does not pull on catheter.		

15. If drainage bag is to be reapplied later, remove cap, swab end with alcohol, and replace cap.		
16. Remove and clean equipment.		
17. Remove and appropriately dispose of gloves.		
18. Wash hands.		
19. Store equipment.		
20. Make client comfortable.		
21. Place call device within reach, if appropriate.		
22. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "CHANGE A DRAINAGE BAG" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

630

Lesson 3: Bowel Elimination

Skill Sheet

ADMINISTER AN UNMEDICATED ENEMA

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Enema bag, tubing and clamp
2. Bedpan or bedside commode
3. Lubricant
4. Toilet tissue
5. Paper towels
6. Basin with warm water
7. Soap
8. Washcloths, towel
9. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Put on gloves.		
3. Assemble necessary equipment.		
4. Identify and greet client.		
5. Identify self.		
6. Explain what you are going to do.		
7. Provide privacy.		
8. Have client empty his or her bladder; assist with bedpan or bedside commode.		
9. Client should be in bed, with head of bed flat if possible; cover client with bath blanket and turn down top bedding.		
10. Place bed protector under buttocks.		
11. Assist client to turn or turn client to left side with knees flexed, if possible.		
12. Place bedpan at foot of bed or bedside commode near bed if client cannot go to bathroom.		
13. Clamp enema tubing; fill enema bag with amount of solution ordered by physician.		

14. Expel air from tubing by allowing a small amount of solution to flow into bedpan or bedside commode, then clamp or pinch tubing a few inches from tip.		
15. Put about a teaspoon of lubricant on piece of toilet paper. Rub lubricant on lower three inches of tube.		
16. Raise upper buttock to expose anus.		
17. Ask client to take a deep breath while you insert tip of rectal tube. Rotate tip slowly as you insert it about three inches. If you feel resistance or if client complains of pain, remove tube, cover client and notify supervisor.		
18. Release lifted buttock and unclamp tubing. Hold bag or place it so that level of solution is never higher than 12 inches above anus.		
19. Adjust flow of solution for client's comfort; lower bag if client complains of cramping.		
20. Have client take deep breaths through mouth to relax him or her during flow of solution.		
21. If client has severe cramps or pain that does not pass, starts perspiring heavily or feels faint, discontinue enema and notify the supervisor.		
22. If client has trouble holding solution, stop flow for a few minutes and then start again.		
23. Clamp tube when solution is taken and remove tube, rotating it slowly and gently as you pull it out. Wrap tube in paper towel.		
24. Ask client to retain solution as long as possible. You can assist by applying slight pressure over anal region by holding or pressing buttocks together.		
25. Assist client onto bedpan or bedside commode, or assist to toilet. If client is taken to bathroom, instruct client not to flush toilet so results can be checked.		
26. Place call device and toilet tissue within reach.		
27. Remove and appropriately dispose of gloves.		
28. Wash hands.		
29. Leave room unless assistance is needed.		
30. Check on client after five minutes or when client calls.		
31. Wash hands.		
32. Put on gloves.		

33. When client is finished, remove bedpan or bedside commode and observe results, noting characteristics of stool.		
34. Clean perineal area with wet washcloth and dry thoroughly.		
35. Give client a clean, wet washcloth to wash hands.		
36. Place soiled washcloths in appropriate container.		
37. Remove, clean and store equipment.		
38. Remove and appropriately dispose of gloves.		
39. Wash hands.		
40. Make client comfortable.		
41. Place call device within reach, if appropriate.		
42. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "ADMINISTER AN UNMEDICATED ENEMA" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 4: Ostomies

Skill Sheet

CHANGE AN OSTOMY BAG

Student Name ________________________________ Date ____________

EQUIPMENT:

1. Bedpan
2. Bed protector
3. Bath blanket
4. Clean ostomy equipment
5. Toilet tissue
6. Basin with warm water
7. Soap or cleanser
8. Washcloths, towel
9. Plastic waste bag
10. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Assemble equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Fold bed linens to bottom of bed.		
7. Cover client with bath blanket.		
8. Place disposable bed protector under client's hips.		
9. Place bedpan within easy reach.		
10. Place basin, soap, washcloth and towel within easy reach.		
11. Wash hands.		
12. Put on gloves.		
13. Expose ostomy and remove soiled ostomy bag. If disposable type, place in plastic waste bag. If reusable, place in bedpan.		
14. Wipe area around stoma with toilet tissue.		
15. Dispose of tissue in plastic bag.		
16. Cleanse around stoma with soap and water.		

17. Dry thoroughly.		
18. Apply clean ostomy appliance.		
19. Remove disposable bed protector.		
20. Replace bed linens and remove bath blanket. NOTE: Use steps of procedure to make an occupied bed.		
21. Remove equipment.		
22. If reusable ostomy bag is used, take to bathroom and empty into toilet. Clean out reusable bag using soap and water.		
Place on paper towel in bathroom to dry.		
23. Clean and store equipment.		
24. Remove and appropriately dispose of gloves.		
25. Wash hands.		
26. Give client clean, wet washcloth to wash hands.		
27. Place soiled washcloth in appropriate container.		
28. Wash hands.		
29. Make client comfortable.		
30. Place call device within reach, if appropriate.		
31. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "CHANGE AN OSTOMY BAG" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 5: Specimen Collection

Skill Sheet

COLLECT A MIDSTREAM CLEAN-CATCH URINE SPECIMEN

Student Name ______________________________ Date ____________

EQUIPMENT:

1. Clean-catch disposable collection kit
2. Goggles or protective eyewear
3. Bedpan, urinal or bedside commode
4. Labeled specimen container
5. Plastic sack for specimen
6. Basin with warm water
7. Soap
8. Washcloths, towel
9. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Allow client to collect specimen if he or she can do so. Assist client if necessary.		
8. Offer bedpan or urinal or assist client to bathroom or bedside commode.		
9. Wash hands.		
10. Put on gloves and goggles.		
11. Clean penis or perineal area carefully with towelettes or washcloth and soap.		
12. For female client, keep labia separated until specimen is collected. For uncircumcised male, keep foreskin pulled back until specimen is collected.		
13. Ask client to begin urinating.		
14. Ask client to stop urine stream.		

15. Hold specimen container where it will catch urine stream. Be sure container does not touch client. If container touches client, it is contaminated and procedure must be repeated.		
16. Ask client to start urinating again. If client cannot stop urinating, move container into stream to collect midstream specimen.		
17. Ask client to stop urine stream when specimen has been collected. Remove specimen container and allow client to finish urinating.		
18. Put lid on container immediately. DO NOT TOUCH inside of lid.		
19. Label specimen container. Record date and time of collection.		
20. Place container in plastic sack. Do not contaminate outside of sack.		
21. Clean penis or perineal area with wet washcloth and dry thoroughly.		
22. Remove, clean and store equipment. Discard disposables in proper receptacles.		
23. Remove gloves and goggles and appropriately dispose of gloves.		
24. Wash hands.		
25. Give client clean, wet washcloth to wash hands.		
26. Place soiled washcloth in appropriate container.		
27. Wash hands.		
28. Make client comfortable.		
29. Place call device within reach, if appropriate.		
30. Take urine specimen to designated area.		
31. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "COLLECT A MIDSTREAM CLEAN-CATCH URINE SPECIMEN" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 5: Specimen Collection

Skill Sheet

COLLECT A 24-HOUR URINE SPECIMEN

Student Name ____ Date ________________

EQUIPMENT:

1. Large container with label denoting 24-hour specimen
2. 2 tags; one for client's bed, one for client's bathroom - to indicate 24-hour specimen collection
3. Bedpan, urinal or bedside commode
4. Lab requisition slip
5. Goggles or protective eyewear
6. Large bucket filled ½ full of ice or preservative
7. Wet washcloth
8. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Place large labeled specimen container in bathroom. To control odors and bacterial growth, place container in ice bucket or obtain preservative from laboratory. NOTE: If ice is used, replace as necessary.		
8. Place tags by client's bed and in client's bathroom to alert all personnel that 24-hour specimen is being collected.		
9. At beginning of collection period, have client void and discard urine to make sure bladder is completely empty. (NOTE: Use steps of procedure for assisting client with urinal or bedpan.) Record time to start 24-hour collection period, which will continue until same time next day. Collect all other urine voided during this period.		
10. Offer bedpan or urinal, or assist client to bathroom or bedside commode.		

11. Wash hands.		
12. Put on gloves and goggles		
13. Ask client to void. DO NOT discard toilet tissue in bedpan or collecting utensil; provide plastic bag or wastebasket for toilet paper. Remind client not to have bowel movement, if possible.		
14. Remove bedpan or urinal, or assist client back to bed, if necessary.		
15. If client's fluid intake and output are being recorded, measure and record amount of urine each time client voids.		
16. Pour urine into large container. NOTE: If any urine is spilled or discarded, test must be restarted.		
17. Clean penis or perineal area with wet washcloth and dry thoroughly.		
18. Remove, clean and store equipment. Discard disposables in proper receptacles.		
19. Remove gloves and goggles and appropriately dispose of gloves.		
20. Wash hands.		
21. Give client clean, wet washcloth to wash hands.		
22. Place soiled washcloth in appropriate container.		
23. Wash hands.		
24. Make client comfortable.		
25. Place call device within reach, if appropriate.		
26. At end of collection period, take specimen and laboratory slip to laboratory. Remove 24-hour tags.		
27. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "COLLECT A 24-HOUR URINE SPECIMEN" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 5: Specimen Collection

Skill Sheet

COLLECT A STERILE URINE SPECIMEN FROM A CLOSED URINARY DRAINAGE SYSTEM

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Syringe with attached needle
2. Sterile specimen container with label
3. Lab requisition slip
4. Antiseptic solution
5. Alcohol sponge
6. Soap and water
7. Washcloths, towel
8. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Put on gloves.		
3. Assemble necessary equipment.		
4. Identify and greet client.		
5. Identify self.		
6. Explain what you are going to do.		
7. Provide privacy.		
8. Close clamp on drainage tubing below speci-port. NEVER leave bedside at this time without unclamping tubing.		
9. Cleanse speci-port with alcohol sponge.		
10. Remove needle cover from syringe.		
11. Insert needle into speci-port and gently pull back on plunger to obtain required amount of urine.		
12. Remove needle and syringe from speci-port. Cleanse speci-port with alcohol sponge.		
13. Open clamp on drainage tubing. Check to see that urine is draining into drainage bag.		
14. Place needle of syringe into specimen container and push plunger to expel urine into container.		

15. Close container tightly. Label container.		
16. Pour leftover urine into toilet or hopper.		
17. Remove, clean and store equipment. Discard disposables in proper receptacles.		
18. Remove and appropriately dispose of gloves.		
19. Wash hands.		
20. Make client comfortable.		
21. Place call device within reach, if appropriate.		
22. Take specimen to designated area.		
23. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "COLLECT A STERILE URINE SPECIMEN FROM A CLOSED URINARY DRAINAGE SYSTEM" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 5: Specimen Collection

Skill Sheet

COLLECT A STOOL SPECIMEN

Student Name ______________________________ Date ____________

EQUIPMENT:

1. Bedpan and cover
2. Labeled specimen container
3. Tongue depressor
4. Plastic bag or wastebasket for toilet paper
5. Toilet tissue
6. Wet washcloth
7. Paper towel
8. Lab requistion slip
9. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Put on gloves.		
3. Assemble necessary equipment.		
4. Identify and greet client.		
5. Identify self.		
6. Explain what you are going to do.		
7. Provide privacy.		
8. Give client bedpan or assist to bedside commode or to bathroom fitted with speci-pan.		
9. Ask client not to urinate or put toilet tissue into receptacle. Provide plastic bag or wastebasket for toilet paper.		
10. Give client clean, wet washcloth to wash hands, if necessary.		
11. Place soiled washcloth in appropriate container.		
12. Take covered bedpan to client's bathroom or to dirty utility room.		
13. Using wooden tongue depressor, take about one to two tablespoons of feces from different areas of stool and place into specimen container. DO NOT TOUCH inside of lid or container.		
14. Cover specimen container securely and label container.		
15. Place container in plastic bag for transporting to laboratory.		

16. Empty remaining stool into toilet or hopper.		
17. Remove, clean and store equipment. Wrap tongue depressor in paper towel and discard it and other disposables in proper receptacles.		
18. Remove and appropriately dispose of gloves.		
19. Wash hands.		
20. Make client comfortable.		
21. Place call device within reach, if appropriate.		
22. If specimen is not sent to lab immediately, store according to acility's policy. Stool specimens are NEVER refrigerated.		
23. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "COLLECT A STOOL SPECIMEN" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 5: Specimen Collection

Skill Sheet

COLLECT A SPUTUM SPECIMEN

Student Name ______________________________ Date ____________

EQUIPMENT:

1. Sputum specimen container with lid
2. Label - correctly filled out
3. Glass of water
4. Emesis basis
5. Tissues
6. Paper bag
7. Lab requistion slip
8. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Put on gloves.		
3. Assemble necessary equipment.		
4. Identify and greet client.		
5. Identify self.		
6. Explain what you are going to do.		
7. Provide privacy.		
8. Have client rinse out mouth with water and spit into emesis basin.		
9. Have client hold container. Instruct him or her to only touch outside of container.		
10. Tell client to take three deep breaths in a row, and on third, exhale and cough deeply from within lungs to bring up sputum. Have client cover mouth and nose with tissue when coughing.		
11. Have client spit sputum directly into container.		
12. Collect one to two tablespoons of sputum. Client may need to cough several times to bring up this amount of sputum.		
13. Immediately put lid on container.		
14. Label container. Record date and time of collection.		
15. Remove, clean and store equipment. Discard disposables in proper receptacles.		

16. Remove and appropriately dispose of gloves.		
17. Wash hands.		
18. Make client comfortable.		
19. Place call device within reach, if appropriate.		
20. Take specimen to designated area. Sputum MUST BE tested before it begins to dry.		
21. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "COLLECT A SPUTUM SPECIMEN" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 6: Heat and Cold Application

Skill Sheet

APPLY A WARM, MOIST COMPRESS

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Basin of water
2. Bath thermometer
3. Compress - small towel, washcloth or gauze squares
4. Plastic wrap
5. Ties, tape or rolled gauze
6. Bath towel
7. Waterproof bed protector

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Position client in comfortable position.		
8. Place waterproof bed protector under body part that is to receive moist compress.		
9. Fill basin ½ to 2/3 full with hot water. Temperature should be as directed by physician or physical therapist.		
10. Place compress into hot water.		
11. Wring out compress so water is not dripping from it.		
12. Apply to specified area and note time of application.		
13. Cover compress with plastic wrap and then with bath towel.		
14. Secure towel in place with ties, tape or rolled gauze.		
15. Place call device within reach.		
16. Check area after initial five minutes.		

17. Remove moist compress after 20 minutes; pat dry with a towel.		
18. Remove, clean and store equipment.		
19. Wash hands.		
20. Make client comfortable.		
21. Place call device within reach.		
22. Record observations and report anything unusual to supervisor.		

The student has satisfactorily completed the procedure "APPLY A WARM, MOIST COMPRESS" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

647

Lesson 6: Heat and Cold Application

Skill Sheet

APPLY A WARM WATER BOTTLE

Student Name ________________________________ Date ______________

EQUIPMENT:

1. Warm water bottle
2. Cover (flannel)
3. Towel
4. Bath thermometer
5. Water (temperature should be as directed by physician or physical therapist)
6. Graduate

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Rinse warm water bottle with hot tap water; test for leaks.		
8. Fill graduate with warm water and test temperature with bath thermometer. Temperature should be as directed by physician or physical therapist.		
9. Pour warm water into bag until approximately ½ full.		
10. Expel air from bottle.		
11. Close opening.		
12. Dry top and neck of bottle.		
13. Apply flannelette cover or wrap in dry towel to prevent burns and to secure in place.		
14. Apply as ordered.		
15. Record time, temperature of water, and area to which it is applied.		

16. Place call device within reach.		
17. Check client's skin area and dryness of warm water bottle cover after initial five minutes and every 30 minutes thereafter to prevent burns.		
18. Remove, clean and store equipment. a. Dry inside and outside of bottle.		
b. Store inflated in cool place.		
19. Wash hands.		
20. Make client comfortable		
21. Place call device within reach.		
22. Record observations and report anything unusual to supervisor.		

The student has satisfactorily completed the procedure "APPLY A WARM WATER BOTTLE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion)

Date

Lesson 6: Heat and Cold Application

Skill Sheet

APPLY AN AQUATHERMIA PAD

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Aquathermia pad
2. Distilled water
3. Cover for pad

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Place pad in cover. DO NOT USE PINS!		
8. Place water reservoir container on bedside table.		
9. Arrange tubing at level of pad. Do not allow tubing to hang below level of bed.		
10. Very carefully and gently apply pad to body area. Note time pad is applied.		
11. Check skin under pad after initial five minutes and every 30 minutes thereafter to prevent burns.		
12. Remove aquathermia pad at end of treatment period.		
13. Remove, clean and store equipment.		
14. Make the client comfortable		
15. Place call device within reach.		
16. Wash hands.		

17. Record time applied, length of treatment and area to which it was applied		
18. Record observations and report anything unusual to supervisor.		

The student has satisfactorily completed the procedure "APPLY AN AQUATHERMIA PAD" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 6: Heat and Cold Application

Skill Sheet

APPLY AN ICE BAG OR ICE CAP

Student Name ________________________________ Date ______________

EQUIPMENT:

1. Ice bag or ice cap and wrapper
2. Basin
3. Scoop or spoon
4. Ice

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Test equipment for leaks by filling with water. NOTE: This is usually done outside client's area.		
8. Use clean basin and scoop or spoon to collect ice.		
9. Fill ice bag or ice cap ½ to 2/3 full.		
10. Expel all air.		
11. Dry outside of bag or cap. NOTE: If moisture is left on bag, it may penetrate and cause injury.		
12. Apply cover (fitted wrapper or towel pinned around equipment).		
13. Apply bag or cap against indicated area.		
14. Place call device within reach.		
15. Check the client's skin for signs of complications after the first five minutes; continue checking every 30 minutes until treatment is discontinued.		

16. Remove bag or cap when time has elapsed.		
17. Discontinue application at two-hour intervals or per physician's order.		
18. Remove, clean and store equipment. a. Dry exterior.		
b. Hang upside-down with cap open.		
c. Store appliance inflated and closed in cool place after drying.		
19. Wash hands.		
20. Make client comfortable		
21. Place call device within reach.		
22. Record observations and report anything unusual to supervisor.		

The student has satisfactorily completed the procedure "APPLY AN ICE BAG OR ICE CAP" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 7: Wound Care

Skill Sheet

PERFORM CLEAN, NONMEDICATED DRESSING CHANGES

Student Name ______________________________ Date ______________

EQUIPMENT:

1. New dressing
2. Tape
3. Paper or plastic sack
4. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client.		
4. Identify self.		
5. Explain what you are going to do.		
6. Wash hands.		
7. Put on gloves.		
8. Expose dressing.		
9. Remove old dressing.		
10. Observe and record (if appropriate) amount and color of drainage on old dressing.		
11. Place in paper or plastic sack.		
12. Observe wound.		
13. Remove and appropriately dispose of gloves in paper or plastic sack.		
14. Wash hands.		
15. Open clean dressing.		
16. Touching only edge of clean dressing, lay it over wound.		
17. Apply tape.		

18. Make client comfortable.		
19. Place call device within reach, if appropriate.		
20. Remove, clean and store equipment.		
21. Discard soiled dressing in appropriate container.		
22. Wash hands.		
23. Record pertinent observations and report unusual occurrences to supervisor.		

The student has satisfactorily completed the procedure "PERFORM CLEAN, NONMEDICATED DRESSING CHANGES" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 7: Wound Care

Skill Sheet

PERFORM PREVENTIVE MEASURES FOR PRESSURE ULCERS

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Basin with warm water
2. Soap
3. Towel
4. Lotion
5. Gloves
6. Clean linen, if necessary

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands. NOTE: If drainage is present, gloves must be worn.		
2. Assemble necessary equipment.		
3. Identify and greet client.		
4. Identify yourself.		
5. Explain what you are going to do.		
6. Check turning schedule.		
7. Observe reddened areas.		
8. Wash skin area with soap and water if soiled.		
9. Gently massage skin around any reddened area with warmed lotion.		
10. Place clean linen on bed if necessary.		
11. Tighten linen (must be free from wrinkles).		
12. Turn client to side listed on turning schedule.		
13. Make client comfortable.		
14. Place call device within reach, if appropriate.		
15. Remove, clean and store equipment.		
16. Wash hands.		
17. Record care given, time it was given and side to which client was turned.		

18. Record pertinent observations and report unusual occurrences to supervision.		

The student has satisfactorily completed the procedure "PERFORM PREVENTIVE MEASURES FOR PRESSURE ULCERS" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

Lesson 8: Caring for the Terminally Ill and the Deceased

Skill Sheet

POSTMORTEM CARE

Student Name ______________________________ Date ______________

EQUIPMENT:

1. Basin with warm water
2. Soap
3. Washcloths, towels
4. Comb or brush
5. Waterproof bed protector
6. Clean linen
7. Denture cup and labeled container, if appropriate
8. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Put on gloves.		
3. Flatten bed and straighten body.		
4. Elevate head of bed slightly.		
5. Close eyes by gently holding them in place a few moments.		
6. Place dentures in cup and label container.		
7. Cleanse body.		
8. Comb hair.		
9. Cover client with clean linen up to shoulders.		
10. Arrange linen neatly.		
11. Straighten room and remove medical equipment.		
12. Provide privacy for family.		
13. Remove and appropriately dispose of gloves.		
14. Wash your hands.		
15. Take client's jewelry and belongings to supervisor.		

The student has satisfactorily completed the procedure "POSTMORTEM CARE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion)

Date

Nurse Assistant Competency Record

Name and Address: ____

Directions: Evaluate the student by checking the appropriate number or letter to indicate the degree of competency. The rating for each task should reflect **employability readiness** rather than the grades given in class.

Rating Scale:
3 Mastered - can work independently with no supervision
2 Requires Supervision - can perform job completely with limited supervision
1 Not Mastered - requires instruction and close supervision
N No Exposure - no experience or knowledge in this area

(IBM) 6-98

NOTE: The code in parentheses is the competency identification number used in computerized management systems.

☐ Successfully completed the Health Care Assistant Core Competencies

3	2	1	N	**A. Introduction to Nursing**
				1. Define the role of a nurse assistant in acute, long-tem and home health care. (A001)
				2. Identify health care team members and each of their roles. (A002)
				3. Organize workload and prioritize tasks. (A003)
				4. Follow a chain of command. (A004)
				Other ______________________________
				______________________________

3	2	1	N	**B. Employment**
				1. Describe the job search process. (B001)
				2. Identify requests that are beyond the nurse assistant's training. (B002)
				3. Implement techniques to manage stress. (B003)
				Other ______________________________
				______________________________

3	2	1	N	**C. Interpersonal Relationships and Communication Skills**
				1. Participate as a team member. (C001)
				2. Provide quality health care. (C002)
				3. Exhibit sensitivity to the diversity of others. (C003)
				4. Exhibit tolerance to challenging clients and/or families. (C004)
				5. Exhibit sensitivity to clients' and/or families' pain and loss. (C005)
				6. Communicate pertinent information at the shift change. (C006)
				7. Chart observations and procedures. (C007)
				8. Recognize and report incidents. (C008)
				9. Complete incident reports. (C009)
				10. Reinforce client teaching identified on the care plan. (C010)
				11. Maintain client confidentiality. (C011)
				Other ______________________________
				______________________________

3	2	1	N	**D. Safety**
				1. Follow OSHA guidelines. (D001)
				2. Respond appropriately to hazards and home safety concerns. (D002)
				3. Respond appropriately to community emergencies. (D003)
				4. Review the home safety plan with the client and others providing care in the home. (D004)
				5. Carry out the home safety plan if an emergency occurs during the home visit. (D005)
				6. Apply CDC isolation precautions to client situations. (D006)
				7. Adapt infection-control procedures to limitations in the home. (D007)
				8. Use physical crisis intervention. (D008)
				Other ______________________________
				______________________________

3	2	1	N	**E. Personal Care**
				1. Maintain hearing aids. (E001)
				2. Insert and remove a hearing aid. (E002)
				3. Maintain eyeglasses. (E003)
				4. Place and remove eyeglasses. (E004)
				5. Assist clients to dress. (E005)
				6. Assist clients to undress. (E006)
				7. Give a complete bed bath. (E007)
				8. Give a tub bath. (E008)
				9. Give a whirlpool tub bath. (E009)
				10. Give a shower bath. (E010)
				11. Shave the client with a safety razor. (E011)
				12. Shave the client with an electric razor. (E012)
				13. Comb or brush hair. (E013)

3	2	1	N	E. **Personal Care (continued)**
				14. Give a shampoo during a tub or shower bath. (E014)
				15. Give a bed shampoo. (E015)
				16. Assist with oral hygiene for a conscious client. (E016)
				17. Provide flossing of teeth. (E017)
				18. Administer oral hygiene to helpless or unconscious clients. (E0018)
				19. Provide denture care. (E019)
				20. Give fingernail care. (E020)
				21. Give toenail care. (E021)
				22. Give perineal care to a female client. (E022)
				23. Give perineal care to a male client. (E023)
				24. Give perineal care to a client with a catheter. (E024)
				Other ____________________
				____________________

3	2	1	N	F. **Restorative Nursing**
				1. Assist or raise a client's head and shoulders. (F001)
				2. Move helpless client to the head of the bed. (F002)
				3. Move or assist client to the head of the bed. (F003)
				4. Move a client to one side of the bed. (F004)
				5. Turn client to his or her side. (F005)
				6. Turn client to a prone position. (F006)
				7. Transfer a client from bed to chair. (F007)
				8. Transfer a client from chair to bed. (F008)
				9. Transfer a client using a mechanical lift. (F009)
				10. Transfer a client from bed to gurney. (F010)
				11. Transfer a client using a three-person carry transfer. (F011)
				12. Transfer a client using a two-person sitting transfer. (F012)
				13. Ambulate client with a gait belt. (F013)
				14. Ambulate client who is using a walker. (F014)
				15. Ambulate client who is using a cane. (F015)
				16. Ambulate a client who is using crutches. (F016)
				17. Perform range of motion exercises. (F017)
				18. Assist with active range of motion exercises. (F018)
				Other ____________________
				____________________

3	2	1	N	G. **Nutrition**
				1. Prepare a client for a meal. (G001)
				2. Distribute trays, assisting with tray set-up. (G002)
				3. Feed a helpless client. (G003)
				4. Modify feeding technique as appropriate for a client's condition. (G004)
				5. Distribute drinking water. (G005)
				6. Measure and record intake and output. (G006)
				7. Convert household measurements to metric equivalents. (G007)
				8. Convert a measurement of pounds into kilograms and one of kilograms into pounds. (G008)
				9. Convert a measurement of inches into feet and inches and one of feet and inches into inches. (G009)
				10. Measure client's weight and height. (G010)
				11. Measure weight and length of infant. (G011)
				Other ____________________
				____________________

3	2	1	N	H. **Special Procedures**
				1. Assist client with a urinal. (H001)
				2. Assist client with bedpan. (H002)
				3. Change urinary drainage bag. (H003)
				4. Change adult incontinent brief. (H004)
				5. Administer unmedicated enemas. (H005)
				6. Change ostomy bag. (H006)
				7. Collect a midstream clean-catch urine specimen. (H007)
				8. Collect a 24-hour urine specimen. (H008)
				9. Collect a sterile urine specimen from a catheter. (H009)
				10. Collect a stool specimen. (H010)
				11. Collect a sputum specimen. (H011)
				12. Apply warm, moist compress. (H012)
				13. Apply warm water bottle. (H013)
				14. Apply aquathermia pad. (H014)
				15. Apply ice bag or ice cap. (H015)
				16. Perform clean, nonmedicated dressing changes. (H016)
				17. Give pressure ulcer care. (H017)
				18. Perform post-mortem care. (H018)
				Other ____________________
				____________________

Certificate of Achievement

This is to certify that

____

Achieved the Competencies as Acknowledged for
Nurse Assistant in Acute, Home Health
and Long-Term Care Settings
And is Therefore Recognized

This ________ Day of ________, 19 ___

____
Instructor

____
Administrator